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ABSTRACT

This guide outlines the process of screening preschool-age children in North Dakota to determine their need for special education services. As mass screenings were found to lack cost-effectiveness, selective screening is encouraged. A periodic selective screening process, using a coordinated, interagency approach, is recommended for the earliest possible identification of children with disabilities out of a population of at-risk children. A section on program planning addresses interagency team building, interagency agreements, screening eligibility criteria, role of various staff, public awareness, and screening program evaluation. Implementation of the screening program involves referral procedures, scheduling appointments, site arrangements, transportation arrangements, and screening activities. Follow-up procedures include record-keeping, correspondence, and data management. A question-and-answer section considers potential problem areas. A list of over 40 screening tools for identifying developmental delays in young children is provided. Appendices provide guidelines on writing interagency agreements and sample agreements, eligibility criteria, a developmental history form, and various other forms and support materials. (JDD)

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THREE TO FIVE

SELECTIVE SCREENING

GUIDE

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INTRODUCTION

Background

Historically, EHA-B funds have been available to local special education units for a broad range of child identification activities. Mass screening of all children within a specified age group was one allowable activity used by many local units. These screenings may have been coordinated with other local agencies or they may have been operated independently by a local special education unit.

The one-time mass screening process does not lend itself well to the preschool-aged population. Because of their developmental characteristics, young children may perform inconsistently or not at all in the novel screening environment. Equal time is frequently planned for each child, providing adequate observational time for the youngster who is performing at expectancy for his/her age level, but insufficient time for the child whose performance is not at expectancy or who does not become involved in the tasks that are presented. The result of this process is expenditure of considerable professional time with children for whom no prior concerns existed. The one time look at children who performed poorly, marginally or not at all may give insufficient or confusing information to personnel called upon to make decisions about the need for further evaluation, recommendations to parents, or follow-up by other agencies such as health professionals.

Various other concerns have been identified over the years relating to the cost-effectiveness of mass screenings. Most specifically, the concerns relate to the time spent by professionals in planning, implementing and follow up screening activities, and the loss of services to handicapped children at these times. Recent estimates by various local special education units conducting mass screenings indicate that better than 70% of the children screened have no suspected developmental delays, and of the fewer then 30% that show delays as measured by the screening process, only a small percentage ultimately qualify for services.

The October 20, 1989, Education of the Handicapped Law Report included a response from the Office of Special Education Programs to a request from the state of Alabama regarding the use of EHA-B funds for mass screenings. The OSEP response indicated that EHA-B funds can no longer be used for mass screenings. These funds can only be used for screening of children suspected of having a handicapping condition or who have been determined to have an identified handicapping condition.

STATEMENT OF RATIONALE

The North Dakota Special Education Division:

- will only approve EHA-B plans for expenditure of funds for selective screenings of children referred as at risk of having a handicapping condition or who are handicapped.
- recommends that the regional Early Childhood Tracking teams, with their multi-agency approach, act as a vehicle to identify appropriate referrals for selective screenings.
- recommends that local units rely on agencies and the general community for referrals of children at risk of having a handicapping condition.
- recommends that local special education units coordinate to share costs/resources with other agencies who have responsibilities for screening of young children.

The Department of Public Instruction, Special Education Division believes:

- A periodic selective screening process provides for the earliest possible identification of handicapped children out of a population of at-risk children.
- A selective screening process provides for periodic, consistent monitoring of developmental progress of children previously identified as at-risk.
- A coordinated, interagency approach to selective screening facilitates locating, screening and monitoring of young children, ages three through five at the local level.

PLANNING A SELECTIVE SCREENING PROGRAM FOR AT-RISK POPULATIONS

A change from mass screening to selective screening dictates a substantially different approach to the population to be screened. The focus shifts from screening all preschool children to a selective population of children at-risk. To find these children requires increased collaboration among community agencies and heightened public awareness.

Numerous community agencies already have responsibility to screen young children based on their individual mandates. An interagency approach to screening allows for a coordinated, comprehensive effort where each agency is able to meet its individual screening requirements. A unified screening program promotes sharing of agency resources and information and simplifies family participation in screening efforts.

Interagency Team Building

In building a local interagency selective screening team, the local special education unit will want to consider how services to young children can be enhanced within their community. Networking with previously established teams and/or individual agencies that screen young children can offer a core group from which a selective screening team may be established.

It is recommended that the special education unit collaborate with the NDECTS team in their area. When more than one special education unit is represented on a NDECTS team, the special education units may collaborate screening efforts. The selective screening team may become a subcommittee of the tracking team.

Once selective screening team membership is determined, philosophy and goals for the team can be established, specific roles and responsibilities of each member agency identified, and areas of cooperation agreed upon. This will clarify the extent of commitment by each agency and allow for discussion regarding the sharing of fiscal responsibilities, personnel and materials. Included in this guide is a sample team planning grid, (see Appendix A), that can be used to facilitate this process.

The selective screening team planning grid may also be used to plan actual screening component activities. Areas to be planned in advance would include 1) site location and setup, 2) scheduling, 3) transportation issues, 4) selection of personnel to be involved and their roles, 5) screening tools, 6) makeup of the screening stations, 7) data collection and management issues, and 8) parent and team exit meeting procedures. Components of the screening implementation phase are discussed in more detail in the following section.

Interagency Agreements

An interagency agreement will formalize arrangements addressed in the planning grid and identify in writing the purposes of the interagency team; the procedures used to implement a selective screening program; and the cooperative efforts regarding sharing of fiscal and other resources and responsibilities. A clearly written agreement will also provide avenues for resolution of issues. Written agreements may include a yearly review clause so that agencies may reassess and reaffirm their involvement on an annual basis. Included in this guide is a section that addresses interagency agreements in more detail (see Appendix B).

Screening Eligibility Criteria

Each selective screening team will need to determine eligibility criteria for referrals. This criteria will be used by agencies and teams in selecting appropriate referrals. It may also be used to identify at risk conditions in the case of parent referrals or walk-ins during the screening session. The NDECTS eligibility criteria is included in this guide as a sample of possible criteria. (see Appendix C).

Role of Special Education Unit

Each local special education unit has the responsibility to conduct Child Find and other public awareness activities as means to identifying and locating children suspected of having a handicapping condition ages 0-21.

In an interagency approach, the special education unit has the responsibility for coordination of a local agreement amongst agencies that identifies individual agency roles and responsibilities and contact persons. This agreement would describe the commitment of each agency in the areas of public awareness, referral, screening implementation, screening follow-up activities and data collection.

The special education unit may identify a local screening coordinator. This person would coordinate with the regional NDECTS coordinator in selective screening efforts.

Role of the Regional NDECTS Coordinator

The NDECTS coordinator may serve as a participant or a facilitator of the selective screening team. The NDECTS coordinator is trained to provide assistance in planning the selective screening program; may act as the conduit between the tracking and screening teams (if separate) for referral and follow-up activity information; and may provide data management services for the selective screening team. Specific areas of cooperation may be identified in the local interagency agreement.

Public Awareness

Public awareness is an important component of a selective screening program. Through public awareness activities the community at large, parents of young children, and agencies serving families of young children become knowledgeable about the screening program and possible areas of potential developmental or growth difficulties. Public awareness activities may educate the public and identify eligibility criteria for screening.

Screening Program Evaluation

Ongoing evaluation of the various screening components occurs as the screening process evolves throughout the year. Identification of successful activities that work and areas to expand and modify are addressed by the team.

Selective screening program evaluations should occur in all areas of the screening program, including team functioning. Effectiveness of the program in meeting the goals and objectives of the team would be evaluated.

Information from the evaluation data will form the basis for any screening program changes. Selective screening personnel and screening consumers could provide valuable evaluative information.

IMPLEMENTATION OF A SCREENING PROGRAM

IMPLEMENTATION OF A SELECTIVE SCREENING PROGRAM

The following guidelines have been developed to offer a list of issues to consider as interagency groups develop local plans for implementing a selective screening process. Each local interagency group determines which practices will best meet the needs of children within the area and match the configuration of agencies that will participate in the screening process. This section has been divided into the following implementation procedures: referral, scheduling, site arrangements, transportation, and follow-up activities.

Referral Procedures

When a child reaches at least 36 months of age, referral may occur in one of the following ways:

A. North Dakota Early Childhood Tracking System (NDECTS):

The tracking project coordinator transfers the child's information gathered through the tracking process to the screening team. (A sample authorization form for screening/tracking participants is included in Appendix D.)

B. Agency Referral:

An agency determines a child to be at risk and refers the child to tracking. A formal referral is completed.

C. Parent Referral:

Parents initiate referral inquiries through a predetermined agency representative. Interviews are conducted to verify appropriateness of the referral. (A sample screening referral/developmental history record form is included in Appendix E.)

D. Advertisement:

The local special education unit may assume responsibility to coordinate public service announcements concerning screening opportunities. Media efforts might include development of posters, use of radio, T.V. advertising, newspaper articles, and be conducted one month prior to screening. Units may coordinate with statewide Child Find efforts whenever appropriate.
(A sample public awareness flyer is included in Appendix F.)

Scheduling Appointments

A. Master Schedule:

The local screening coordinator develops a master screening schedule (sample included in Appendix G). An average of one and one half hours per child might be allowed to facilitate a thorough screening of children already considered at-risk.

B. Confirmation to Parent:

At least one week prior to the screening session, the parent receives written notification of his/her child's appointment at the screening session (A sample parent confirmation letter is included in Appendix H).

C. Confirmation to Staff:

Prior to the scheduled screening day, staff members receive a copy of the master schedule from the local coordinator to review in preparation for the screening session.

D. Child's File:

It is recommended that the local screening coordinator prepares an individual file for each child which contains the following: a folder cover sheet, (see Appendix I) health and wellness record (see appendix J.) a screening profile form, (see appendix K.) and any other appropriate forms (eg. tracking information, screening results, previous screening results, etc.).

Site Arrangements

A. Arrangement Agreements:

The local screening coordinator secures an appropriate, accessible screening facility. This facility might include a quiet, uninterrupted setting with multiple rooms and child sized furniture. The local NDECTS Team may be notified of the scheduled screening sites and dates throughout the year to facilitate coordination of referrals, screening and follow-up activities.

B. Screening Site Set-up:

The local screening coordinator arranges for the equipment and material needs of each scheduled screening, including room posters, tables, refreshments, etc. Individual screening team members assume responsibility for bringing their own screening materials to each session.

Transportation Arrangements

A. Transportation Agreements:

Provision of transportation may be addressed through team interagency agreements.

B. Scheduling:

An appointment secretary identifies children who have transportation needs and also plans the day's screening schedule to accommodate convenience in getting numbers of children to and from the screening.

The appointment schedule may need to accommodate children who reside in close proximity.

C. Child - Parent Transport:

When necessary, children and parents are transported to and from screening sessions by a designated agency.

Screening Activities

A. Registration:

At the registration table the parent completes the following screening forms: the screening authorization form (Appendix D); the income verification form, if necessary (Appendix L); the family history form, if not completed previously (Appendix E); and the child's name tag.

Following registration, the child and parent are escorted to the various screening stations.

B. Screening Components:

The screening session might include the measurement of a child's development in the following areas: (1) vision, (2) hearing, (3) health, (4) dental, (5) cognitive, (6) fine motor, (7) gross motor, (8) speech and (9) language. These domains may be reconfigured according to stations to meet the availability of site space and staff.

At each screening station appropriate forms are completed and placed in the child's file. At the discretion of the screener, a parent/child interaction observation form maybe completed (see Appendix M).

C. Parent Exit Conference:

Immediately following the child's screening, an exit conference is held with each parent. A designated team member will review tentative results of the screening, discuss any parent questions or concerns, summarize any future screening or service opportunities, and give the parent a copy of a parent information packet compiled locally. Parent comments are included in the child's file.

D. Screening Team Staffing:

Upon completion of the day's screening session, the screening staff meets to review screening results for each of the children and formulate follow-up recommendations. One person is designated to monitor follow-up activities.

1. Individual Child Reports:

An exit conference chairperson leads discussion of each child's screening results. The entire team reaches consensus regarding recommendations for each child. The team recommendations are recorded on the child's profile sheet (a sample screening profile form is included in Appendix K.) using a screening profile scoring guide. Use of a uniform scoring standard facilitates data management activities. (A sample scoring decision guide is included in Appendix N).

2. Screening/Tracking Team Business:

It is the responsibility of the screening team coordinator to inform team members not attending the screening session of procedural issues discussed during the meeting. Minutes of team business and overall screening summaries are given to the NDECTS Tracking Coordinator for distribution at the next Tracking Team meeting.

FOLLOW-UP PROCEDURES

FOLLOW - UP PROCEDURES

The activities that follow a screening session are equally as important as the actual direct contacts with the children. It is during the follow-up activities that information from the screening team staffing is passed on to the child's family. This information may recommend to the parents: 1) the child be seen by a particular agency for more in-depth assessment or an examination; 2) activities to carry out with the child to enhance or stimulate the child's development within a particular area; 3) schedule the child for another screening within a specific period of time [for example, in four months]; or 4) the child appears to be developing normally and will require no futher follow-up screenings or tracking.

Following the implementation of the screening session are three follow-up activities: record keeping, correspondence and data management.

A. Record Keeping:

The screening coordinator reviews recommendations for each child and prepares the appropriate correspondence to be used in explaining this to parents, agencies, and tracking teams. Screening files will be housed within the agency previously designated through the screening team agreement. Access to these files will be provided to any team member. (A sample screening results report form is included in Appendix O.)

B. Correspondence:

Responsibility for follow-up correspondence may be provided through a prearranged agreement.

1. Parents:

Within a reasonable time period all parents will receive a letter summarizing the screening results and the team recommendations. One copy is enclosed in the child's file and a second copy will be sent to the referring agency when recommended. (Sample letters are included in Appendix P.)

2. Referral to Other Agencies:

If the screening team recommends a referral of a child to another agency for follow-up, a referral form to that agency is completed by the parent giving the selective screening team the authority to contact the referral agency and receive results of that referral. Contacts with that agency are made and verified with the parent. Results are returned to the NDECTS Coordinator or other contact person. (A sample referral and request for information form is included in Appendix Q).

If a referral made to another agency is possibly related to the educational needs of a child, that referral is channeled through the special education unit. If the referral results indicate a need for educationally related services, special education Parent Rights information is given to the parent.

C. Data Management:

The information from the screening is entered on the computerized NDECTS data management system for ease in generation of responses to the family; ease in maintaining and updating records on the child; and compilation of all statewide screening data.

The North Dakota Early Childhood Tracking System maintains a data management system that is being expanded to include information from selective screenings of at risk children, ages 3-5. The computerized data file on each child includes all tracking data accumulated and is updated as new data is received. The NDECTS project coordinator supervises the data management system.

PROBLEM AREA GUIDE

PROBLEM AREA QUESTIONS

1. What is the purpose for an interagency screening?

   A variety of agencies who serve young children have responsibilities for screening. The purposes for the screenings may differ across agencies. By forming a partnership of agencies cooperating in one community based screening effort, the scope of the screening effort is broadened allowing for each agency to obtain the information it requires and for parents to optimize their contacts with community services. The pooling of all the information gathered on each child maximizes on the use of time and personnel resources across agencies.

   EXAMPLE: Head Start screens in areas of development, medical, nutrition, dental, vision, and hearing. Public Health screens in areas of hearing, vision, dental, physical assesments and immunizations etc.

2. What is the role of special education within an interagency agreement?

   An interagency agreement should identify the purposes of the screening and lay out the roles and responsibilities of each agency within the screening process. Inherent within an interagency approach is the concept that all agencies have equal responsibility to ensure that the components of the agreement are carried out as agreed upon.

3. What might be the fiscal responsibility of a special education unit within an interagency agreement regarding a selective screening approach?

   Local education units are mandated to locate, identify and evaluate children suspected of having a handicapped condition, ages zero through twenty-one. In an interagency approach to screening the local unit can tap into other agencies who are also mandated to provide screening services and share the responsibilities. Fiscal expenditures do not need to fall on one agency but can be combined with many agencies. Often agencies are able to share resources and time rather than actual dollars. In doing so, the unit sees the benefit through sharing of personnel. It would be up to the LEA to coordinate and facilitate a selective screening program. However, through local interagency agreements delineation of actual cost responsibilities can be identified amongst the participating agencies. Agreements can be updated yearly in order that agencies may re-assess their commitment in relation to any changes in agency policy and availability to commit resources.

4. Are the procedures prescribed in the selective screening training guide mandatory?

   The selective screening guide is meant to be only a guide to local education units in the provision of an interagency approach for children referred to screening. It offers assistance to units in providing a screening program that is best for children. How the guide will be used at the local level will largely be determined by the style of screening to be used and the extent of interagency involvement within the community.

5. Is selective screening a part of the Early Childhood Tracking System?

The Early Childhood Tracking project monitors at-risk children and was established separate from any special education screening program. However, the tracking program, with its interagency focus, has the capability of monitoring the 0-5 population from which special education programs will receive referrals for screening. The Early Childhood Tracking project gathers information on children referred to the tracking teams through a computerized data management system. This system allows for ease in maintaining and updating records on children. The system is currently being expanded to include information from selective screenings of at-risk children. It is therefore appropriate that the local tracking teams be directly involved with the selective screening process.

The state Special Education division recommends that the selective screening teams interface and/or combine with the local tracking teams as both teams will consist of agencies serving children ages 0-5. Teams may remain separate with representatives serving both teams.

6. Where do I go for further information regarding the formulation of the selective screening teams?

At this time, the Grand Forks Special Education Unit, having piloted an interagency selective screening program for the past two years, would serve as a good resource. As other units develop similar programs they will also serve as valuable resources.

The NDECTS coordinators are also appropriate resources as they can share information and experience gained from establishing the tracking team process and the local interagency teams. Pembina county has initiated a selective screening process and is willing to serve as a resource to other units.

7. How is confidentiality to be handled so that it respects the privacy of families within an interagency team process?

The selective screening team is in existence to provide what is best for children. Understanding that commitment, team members will reinforce confidentiality for families. By defining the purposes of the team and the information needed by both the screening program and the individual agencies confidentiality issues that need to be resolved will be clarified at the local level. Agencies will then be clear in sharing with participating families what information is sought and how the information is to be used. This must be clarified with the parents prior to consent to participate in the selective screening program. An interagency agreement may be used to identify how confidentially issues will be addressed. Developing forms that specifically request only the information determined acceptable by the local selective screening team will provide a written method to assure confidentiality.

8. What considerations should go into the selection of screening tools for a selective screening program?

The selection of screening tools would be determined according to the following: purpose of the screening, structure of the screening, agencies involved in the screening and the needs and ages of children within a local area. As a team identifies more clearly the information to be gathered, screening tools may be supplemented by informal methods and/or other commercial tools.

Other teams have found that although much time was spent initially in determining what screening tools would be appropriate, as the team evolved the actual tool used became less important. This was a result of the increased abilities of those screening the children to gather appropriate information and of the team to use the screening information to make appropriate recommentations.

9. How often might selective screening sessions be scheduled and how would they be structured?

The primary concern for all teams is the unique needs of the children. When a referral comes to a team the team would decide what type of screening would be appropriate, the developmental areas needing to be screened and the need for urgency of the screening. For individual child referrals the ability to be flexible in meeting those individual needs is a necessity in scheduling screening options. Determination may be that a child requires some alternative or immediate screening other than that offered by the current screening program or that the child's needs can be met through the current screening program. If alternatives are used, the child is able to participate in the current screening whenever the team decides it is appropriate.

Selective screening sessions are scheduled on a regular basis throughout the year. This maybe translated into monthly, quarterly, bi-monthly, etc. sessions. Staff availabilitv, ruralness of the area, and the population to be served all need to be considered in determining both the structure and frequency for the screenings. Frequency of screenings may vary at different times during the year.

10. Sometimes families will show up at the screening site asking that their child be screened. What are some guidelines for accepting walk-ins or self-referrals?

The selective screening program is for children who are at-risk of a handicapping condition; therefore, at-risk indicators need to be identified prior to children being screened. The following have been developed and may be used to assist in the identification of at-risk indicators: 1. NDECTS has a series of thirty-four indicators they use for determining eligibility of children. 2. A developmental history form filled out by the parents may be used. The interagency team may want to develop their own procedure using some of or combinations of the above.

11. How is information transferred to the tracking team following the screening staffing?

At the end of the screening session the screening staff holds an exit meeting where information on all children screened that day is reviewed. Recommendations for follow-up are made by the team and a person is designated to monitor follow-up activities. The selective screening coordinator collects all recommendations and relates pertinent information to the tracking coordinator. If the tracking coordinator is a participant of the exit meeting, he/she is designated to review screening information with the tracking teams.

DEFINITIONS

DEFINITIONS

Mass Screening - The process of looking at all children within a specific age range with the goal of determining whether the children may exhibit any risk factors.

Selective Screening - The process of looking at selected children referred for screening due to identified risk factors to determine the significance of the risk condition(s) to the child's growth and development. This option also allows following the condition(s) over time.

EHA-B Funds - Federal funds allocated to states as authorized within the Education for the Handicapped Act, Part B, "Assistance for Education of All Handicapped Children". At the local level these funds may be used for screening activities for children suspected of having a disability.

OSEP - The Office of Special Education Programs, a branch of the United States Department of Education.

EHA-B Plans - Three year plans developed by local special education units and sent to the state Special Education Office describing how programs and policies will be implemented in accordance with provisions identified in the Education of the Handicapped Act.

NDECTS - The North Dakota Early Childhood Tracking System is a state-wide, multidisciplinary network of public agencies and private providers which monitors at-risk children, ages 0-5, for possible delays in vital areas of development. The project was established through a collaborative effort of the following three state level agencies: 1. Department of Health 2. Department of Human Services and 3. Department of Public Instruction.

At-risk Children - Children who exhibit one or more biological or enviromental risk factors. (For purposes of this document reference the NDECTS Eligibility Criteria, Appendix C)

Parent Exit Conference - A meeting with the parent(s) of a child immediately following that child's participation in a screening session at which time tentative results of the screening are reviewed by a designated member of the screening team.

Selective Screening Team - An interagency team comprised of agencies serving children ages 0-5 with the purpose of providing a multidisciplinary, community-based approach to selective screening of young children.

Screening Team Staffing - A meeting of the screening team members held upon completion of the day's screening activities to review the results of each child screened and to formulate recommendations for follow-up activities.

Child Find Activities - A system of procedures used by local special education units to locate and identify children who are in need of special education services. Activities may include screening, referral procedures, and public awareness campaigns.

Eligibility Criteria - A set of factors used to determine whether or not a child qualifies for a service. These factors may include at-risk indicators such as a severe chronic illness or condition, maternal age of less than 17 years, genetic defects and/or delays in one or more developmental growth areas.

Screening Components - The areas of a child's development to be measured during a selective screening session. They may include: 1. vision; 2. hearing; 3. health; 4. dental; 5. cognitive; 6. fine motor; 7. gross motor; 8. speech; and 9. language.

Data Management - The computerized system by which individual children's tracking and screening information is recorded, maintained, and electronically transferred. Additional capabilities include generation of standard correspondence, aggregation of data, and reporting functions.

Parent Rights Information - Those rights assured to parents of handicapped children by the Education of the Handicapped Act and other federal legislation, such as the right to be notified prior to changes in a child's program.

Handicapping Condition - A child may be diagnosed as having a handicapping condition in one or more of the following categories: 1. deaf; 2. deaf/blind; 3. hard of hearing; 4. mentally handicapped; 5. multihandicapped; 6. orthopedically handicapped; 7. other health impaired; 8. seriously emotionally distrubed; 9. specific learning disabilities; 10. speech impaired; 11. visually handicapped.

Educationally Related Services - Federal regulations describe related services as "transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training" (34 CFR 300.13a).

SCREENING TOOL BIBLIOGRAPHY

SCREENING TOOL BIBLIOGRAPHY

Numerous screening tools are available for identifying developmental delays in young children. These tools may be standardized, norm referenced, criterion based, parent interview or direct observation. Determination of a particular screening tool to be used in gathering screening information varies according to the purpose of the screening, the structure of the screening and the expertise of the personnel conducting the screening.

Following are lists of various screening tools with identifying characteristics summarized. These lists may be helpful in determining which screening tools are appropriate for use by local screening teams.

SELECTED INFANT AND PRESCHOOL SCREENING TESTS

ASSESSMENT DEVICES	AGE RANGE	TIME IN MINUTES TO ADMINISTER	RELIABILITY	MEAN & SD	TYPE							VALIDITY	PURPOSE / DESCRIPTION / COMMENTS
					CRITERION	NORMATIVE	GROUP	INDIVIDUAL	VERBAL	NON-VERBAL	SCREENING		
Denver Developmental Screening Test (DDST) 1975	0 - 6	20	TR .88 to .93			X		X			X	Concurrent validity with Stanford-Binet, Cattell, and Bayley = .74 to .97 *Sensitivity = .80 **Specificity = .90	The DDST is the best known screening instrument. It screens across four developmental areas: personal-social, fine motor-adaptive, language, and gross motor. This test significantly under refers children.
Developmental Activities Screening Inventory (DASI-II) 1984 Pro-Ed	0 - 6	20-40	not reported		X			X		X	X	Concurrent validity .95 with DDST No sensitivity or specificity data	The test was designed for use with pre-school handicapped children. It is non-verbal in format. There are not enough data on it to validate its usefulness.
Developmental Indicators for the Assessment of Learning Revised (DIAL R) (1983) Childcraft Educational Corporation	2 - 6	25	T/R = .87			X		X			X	Correlations with Stanford-Binet: Motor = .28; Concepts = .50; Language = .33; Overall = .40	This is a team-based screening test with weak predictive validity. The Communications/Language section would tend to underrefer children for further evaluation in this area.
Early Screening Inventory (ESI) (1983) Teachers College Press	3-6	15-20	IR = .91 TR = .91			X		X			X	Concurrent validity with the McCarthy Scales of Children's Ability = .73 *Sensitivity = .92 **Specificity = .95	The ESI serves as a quick inventory to identify those children who may need further evaluation. This test has excellent psychometric properties and has a high "hit" rate, a quality lacking in many screening tests. A Spanish version is being standardized.
Miller Assessment for Preschoolers (MAP) (1982) KID Technologies	2 - 9 to 5 - 8	20 - 30	TR = .81			X		X	X			Content validity.	Provides a normative overview of a child's overall developmental status. All 40 items must be administered to score the test. Three categories are covered: sensory/Motor, cognition, and combined abilities.
Minneapolis Pre-School Screening Instrument (1980) Minneapolis Public Schools	3 years 7 mos to 5 years 4 mos.	15	TR = .92			X		X			X	Concurrent validity with Stanford-Binet = .71 *Sensitivity = .83 **Specificity = .83	The MPSI is a 50 item test with an emphasis on classroom readiness tasks. The test underrefers children at risk.
Minnesota Child Developmental Inventory (MCDI) (1972) Behavior Science Systems	6 mos-6 years	20-30	X = .90			X		X			X	*Sensitivity X = .78 **Specificity X = .78	The MCDI is a 320 item Parent Report Inventory. It over refers children not at risk. Some would question its use as a screening inventory.

*(TR) = Test retest (SH) = Split Half (AF) = Alternate Form (IR) Inter Rater (SEm) = Standard Error of Measurement

* refers to proportion of children at risk correctly identified

** refers to proportion of children not at risk who are correctly excluded from further testing

SELECTED DEVELOPMENTAL INVENTORIES

ASSESSMENT DEVICES	AGE RANGE	TIME IN MINUTES TO ADMINISTER	RELIABILITY	MEAN & SD	TYPE							VALIDITY	PURPOSE / DESCRIPTION / COMMENTS
					CRITERION	NORMATIVE	GROUP	INDIVIDUAL	VERBAL	NON-VERBAL	SCREENING		
Battelle Developmental Inventory (BDI) (1984) DLM Teaching Resources	0 - 8	45 - 90	TR = .71 to 1.0			X		X	X		X	Concurrent validity .66 with PPVT-R .68 with Pre-School Language Scale	The BDI consists of 341 items grouped in 5 domains (1) Adaptive, (2) Cognitive, (3) Communication, (4) Motor, and (5) Personal-Social. Is useful in depicting child progress in intervention programs. More validity data is becoming available.
Brigance Diagnostic Inventory of Early Development (1978) Curriculum Associates	0 - 7	45 - 60	N.A.	N.A.	X			X	X			Consensual validity by experts.	The Brigance assesses pre-ambulatory motor skills and behaviors, gross motor skills and behaviors, fine motor skills and behaviors, self-help skills, pre-speech and language skills, general knowledge and comprehension, and readiness. The items lend themselves readily to educational programming. Validity data not reported in manual.
Callier-Azusa Scales (1978) University of Texas	0 - 5	30 - 40	TR = .88 to .97	N.A.	X			X		X		Content validity only.	A scale designed for use with deaf blind and severely handicapped. Eighteen subscales assess five areas: (1) Motor Development, (2) Perceptual Abilities, (3) Daily Living Skills, (4) Cognitive, Communication, and Language, (5) Social Development. Ratings are obtained through direct observation.
Developmental Profile II. (1980) Psychological Developmental Publications	0 - 9	20 - 30	TR = 1.71 IR = .50 - .92			X		X	X			Content validity only.	A developmental scale that uses parent report to document growth in 5 areas: physical, self-help, social, academic, and communication. Because of weak standardization, it should not be used for classifying children for specific programs.
Gesell Developmental Schedules (1940). Nigel Cox (Cheshire, (CT).	1 month - 6 years	45 - 60	N.A.	N.A.	X			X	X			Consensual validity and content validity.	Provides a developmental diagnosis by assessing the quality and integration of children's development in 5 areas: adaptive, fine motor, gross motor, personal-social, and language.
Learning Accomplishment Profile (LAP-D) (1977) Kaplan School Supply	6 months to 6 years	60 - 90	TR = .82 to .98		X			X	X			Content validity only.	The LAP consists of 323 items in five domains: (1) Cognitive, (2) Fine Motor, (3) Gross Motor, (4) Language/ Cognitive, and (5) Self-Help. The test is designed to evaluate a child's entry skills, and validate the effects of an intervention program. It is probably least useful in the last category because of inadequate norms.
Smith Johnson Non-Verbal Performance Scale (1982). Western Psychological Corp	2 - 4	30 - 45	TR = .27 to .81			X		X	X	X		Content validity and correlations with Leiter	Provides a useful format for observation of tasks frequently included in preschool curricula. Qualitative information is also obtainable. One of the few non verbal tests available.
Uniform Performance Assessment System (UPAS) (1981) Charles E. Merrill	0 - 6	60 - 90	TR = .88 to .95	N.A.	X			X				Content validity only.	The UPAS assesses four curricular areas: (1) Communication, (2) Gross Motor, (3) Preacademic, (4) Fine Motor, and (5) Social/Self Help areas of development. The UPAS is best used to monitor a child's performance through a curriculum.

(TR) - Test-retest (SH) - Split Half (AF) - Alternate Form (IR) Inter Rater (SEm) - Standard Error of Measurement

SELECTED COGNITIVE ASSESSMENT DEVICES

ASSESSMENT DEVICES	AGE RANGE	TIME IN MINUTES TO ADMINISTER	* RELIABILITY	MEAN & SD	TYPE: CRITERION	TYPE: NORMATIVE	TYPE: GROUP	TYPE: INDIVIDUAL	TYPE: VERBAL	TYPE: NON-VERBAL	TYPE: SCREENING	VALIDITY	PURPOSE / DESCRIPTION / COMMENTS
Bayley Scales of Infant Development (1969) Psychological Corp.	2 months to 30 months	Mental: 25 - 30	Mental Scale: .81 to .89	$\bar{X}$ = 100 SD = 16		X		X	X	X		Correlation of .57 was obtained with the Stanford-Binet for a sample of 129 (ages 24 to 30 months) children in the standardization group	One of the most widely used measures of infant development available. The Mental Scales evaluates a variety of activities and processes, including shape discrimination, sustained attention, purposeful manipulation of object, imitation/comprehension, etc. (also see motor).
Kaufman Assessment Battery for Children (KABC) (1983), American Guidance Service	2-6 to 12-6 Years	90	Ages 2-1/2 to 4 Mental Processing Composite (MPC) = .90 Achievement = 80 Ages 12 and Over MPC = .91 Achievement = .97	$\bar{X}$ = 100 SD = 15 for four Global Scales		X		X	X	X		Concurrent validity ranging from .60 to .79 between the MPC and other intelligence tests (WISC-R, Stanford-Binet, and the McCarthy Scales) (GCI). From .75 to .86 between the achievement scales and other intelligence tests.	The K-ABC contains 16 subtests, 10 measuring the MPC and 6 achievement. The MPC is separated into a dichotomy of sequential processing (5 subtests) and simultaneous processing (7 subtests). The game-like nature of the subtests help motivate preschoolers. Socio-cultural norms are provided for minority subjects.
McCarthy Scales of Children's Abilities (1972) Psychological Corporation	2-6 to 8-6 Years	45 to 60 for children below 5; 90 for older children	General Cognitive Index (GCI) = .93 Memory & Motor Scales = .79 to .88 (SH) GCI = .89 Memory & Motor Scales = .68 to .83			X		X	X	X		Concurrent validity is acceptable, with correlations ranging from .45 to .91 (median of .75) using the Stanford-Binet, WISC-R, and WPPSI as criteria.	The McCarthy Scales provides a general level of intellectual functioning (GCI) and a profile of verbal ability, nonverbal ability, number aptitude, short-term memory, and motor coordination. The scales contain 18 subtests grouped into one or more of six scales. Five verbal subtests and three quantitative tests are included in the GCI
Stanford-Binet (Fourth-Ed.) (1986) Riverside Publishing	2 years to Adult	60 to 90	Ages 2 to 5 .74 to .88 Ages 6 to 13 .74 to .91 Ages 13 to 17 .85 to .89	$\bar{X}$ = 100 SD = 16		X		X	X	X		Correlations obtained between the Stanford-Binet and the Bayley Scales .57 Between Stanford-Binet and KABC .62 to .69.	Stanford-Binet provides a continuous scale for assessing cognitive development from age 2 to adult. Assesses verbal reasoning, quantitative reasoning, abstract/visual reasoning, and short-term memory.
Uzgiris Hunt Ordinal Scales of Infant Psychological Development (1975), University of Illinois	0 - 18 months	15 - 60	IR = .84 to .97		X			X	X			No validity data reported. Test is based on Piagetian constructs	This test is constructed following Piagetian sequences I Visual Pursuit to object permanence, II Instrumental Action III Vocal & Gestural Imitation, IV Operational Causality, V Object Relations in space, & VI Developing Object Relations Schema

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SELECTED COMMUNICATION ASSESSMENT INSTRUMENTS

ASSESSMENT DEVICES	AGE RANGE	TIME IN MINUTES TO ADMINISTER	RELIABILITY	MEAN & SD	TYPE							VALIDITY	PURPOSE / DESCRIPTION / COMMENTS
					CRITERION	NORMATIVE	GROUP	INDIVIDUAL	VERBAL	NON-VERBAL	SCREENING		
Birth to Three Developmental Scale (1979). Teaching Resources	0 to 3 years	30	IR = .88 - .99		X			X	X	X	X	.70 - .80 with other language scales.	The Birth to Three Developmental Scale is designed for easy identification of developmental delays in four behavioral categories. It is most useful in identifying strengths and weaknesses and leads directly to educational programming. The test items are designed to be fair to individuals from culturally diverse backgrounds
Early Language Milestone Screening Scale (ELM) (1983). Modern Education Corp.	0 - 3 years	1 - 3				X		X	X	X		Content validity only.	A communication screening test that covers auditory expressive, auditory receptive, and visual skills. Each behavior is developmentally sequenced and percentiles for each age are given.
Expressive One Word Picture Vocabulary Test (EOWPVT) (1979) Academic Therapy Publications	2 to 12 years	5 - 10	SH = .87 to .96			X		X	X		X	Concurrent validity correlations with Peabody Picture Vocabulary Test - .29 to .59.	Designed to assess verbal intelligence by means of acquired expressive picture vocabulary in a picture naming format. Useful in determining the quantity of expressive vocabulary
Peabody Picture Vocabulary Test (PPVT-R) (1981). American Guidance Service	2 1/2 years to adult	10 - 20	.77 average for all studies	$\bar{x}$ = 100 SD = 15		X		X	X	X	X	Concurrent validity .70 with Stanford-Binet and WISC.	The PPVT may be best described as a test of receptive vocabulary. It is most useful in longitudinal studies and in documenting changes in receptive vocabulary due to a language intervention program. Has excellent reliability and validity when used in this restricted way.
Receptive-Expressive Emergent Language Scale (REEL) (1979) University Park Press	0 - 36 months	30				X		X	X	X		Content validity only.	Developed to fill the need for an instrument which could assess receptive and expressive language skills in very young children.
Receptive One Word Picture Vocabulary Test (ROWPVT) (1982) Academic Therapy Publications	2 to 12 years	10 - 15	SH = .87 to .96			X		X		X			Assesses children's single word receptive vocabulary by requiring only a picture pointing response. Has specific clinical utility for non-verbal children.
Sequenced Inventory of Communication Development (SICD) (1984) University of Washington	4 - 48 months	Dependent upon age 30 - 60	TR = .80 IR = .80	$\bar{x}$ = 100 SD = 15		X		X	X	X		Reviewers emphasize construct validity only.	A useful instrument in identification of broad areas in communication development that require intensive clinical prescriptive development. The SICD tests developmental milestones in areas of high validity, if one views communication development as best measured in terms of its interactive function among children and their environmental audiences and initiators. Particularly helpful in placing children along developmental grids.
Test of Early Language Development (TELD) (1981) Western Psychological Ser	3 - 8	15 - 20	TR = .90	$\bar{x}$ = 100 SD = 15		X			X	X		.66 - .80 with Test of Language Development.	The TELD assesses language content and syntax morphology and phonology. Syntax and morphology are assessed both receptively and expressively. Language quotients, percentiles, and language ages are reported

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SELECTED MOTOR ASSESSMENT DEVICES

ASSESSMENT DEVICES	AGE RANGE	TIME IN MINUTES TO ADMINISTER	RELIABILITY *	MEAN & SD	TYPE						VALIDITY	PURPOSE / DESCRIPTION / COMMENTS
					CRITERION	NORMATIVE	GROUP	INDIVIDUAL	VERBAL	NON-VERBAL	SCREENING	
Bayley Scales of Infant Development (1969) Psychological Corp.	2 months to 30 months	Motor: 20-25	Motor Scale: .88 to .92. However, reliabilities tend to be lower for the first 4 months (ages 2 through 5 months)	$\bar{X}$ = 100 SD = 16		X		X		X		Correlation of .57 was obtained with the Stanford-Binet for a sample of 120 (ages 24 to 30 months) children in the standardization group. No correlations for Motor Scale are reported individually.	One of the most widely used measures of infant development available. The Motor Scales covers gross and fine motor abilities, such as sitting, standing, walking, and grasping (also see Mental Scale).
Bruininks-Oseretsky Test of Motor Integration (1967). Follett Publishing Company	4-1/2 to 14-1/2 years	45-60	Battery Composite .88 to .89 Fine and Gross Motor Composite: .88 to .89 (TR)	Composite Scores: $\bar{X}$ = 50 SD = 10 Individual Subtests: $\bar{X}$ = 15 SD = 5		X		X		X		Construct validity was evaluated by the following methods: (1) relation of test scores to CA, (2) internal consistency of subtests, (3) factor structure of individual items. Correlations (product-moment) between subtest scores and CA for standardization sample range from .57 to .86.	The test contains 46 items with a framework of 8 subtests. Four subtests measure gross motor skills, 3 measure fine motor skills, and 1 measures both. Composite scores are obtained for the gross motor subtests, fine motor subtests, and total battery. A short form is also available that can be used as a brief survey of motor proficiency.
The VMI: Developmental Test of Visual Motor Integration (1989). (3rd Rev.) Modern Curriculum Press.	3 to 18 Years	10 - 15	For 171 children: Boys = .83 Girls = .87 (TR) .90's (IR)	Given by age.			X	X		X		Concurrent validity of the test with CA is .88, with WISC-R is .49 (verbal) and .58 (performance), with PIMA is .58, with Frostig is .72.	The VMI contains 24 geometric forms which the child is asked to copy and are arranged in order of increasing difficulty. The total raw score is converted into developmental equivalents and into scale scores, with separate tables for boys and girls.
Milani-Comparetti Motor Development Screening Scale (Modified Edition) (1984). Mayer Children's Rehabilitation Institute	0 - 2 years	10			X			X				Content validity only.	Assesses control of head and body, protective responses, movement from one position to another, locomotion, reflexes, and the child's state. It can be repeated to monitor trends in motor development.
Peabody Developmental Motor Scales (PDMS) (1983) Teaching Resources Corp.	Birth to 83 months	45 to 60	Gross Motor = .95 Fine Motor = .80 TR Gross Motor = .97 Fine Motor = .94 (IR)	Scaled Scores $\bar{X}$ = 500 SD = 100 Develop. Motor Quotients (DMQ) $\bar{X}$ = 500 SD = 15	X			X		X		Concurrent validity between the PDMS Fine Motor total and the Bayley Mental and Psycho-Motor Scales are .78 and .38, respectively.	The PDMS is divided into two components: the Gross Motor and Fine Motor Scale. The Gross Motor Scale contains 170 items divided into 17 age levels (10 items per level) and the Fine Motor contains 112 items divided into 16 age levels (8 or 8 items per level). The Gross Motor items are classified into five skill categories: reflexes, balance, non-locomotor, locomotor, and receipt and propulsion of objects. The Fine Motor scale items are classified into four skill categories: grasping, hand use, eye-hand coordination, and manual dexterity.

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SELECTED SOCIAL / EMOTIONAL ASSESSMENT DEVICES

ASSESSMENT DEVICES	AGE RANGE	TIME IN MINUTES TO ADMINISTER	RELIABILITY	MEAN & SD	TYPE: CRITERION	TYPE: NORMATIVE	TYPE: GROUP	TYPE: INDIVIDUAL	TYPE: VERBAL	TYPE: NONVERBAL	TYPE: SCREENING	VALIDITY	PURPOSE / DESCRIPTION / COMMENTS
Bush's Behavior Rating Scales: Preschool and Kindergarten (1977). Western Psychological Services	3 - 6 years	20 to 30	.74 to .98 on normal children	N.A.		X		X				A panel of 28 kindergarten teachers judged the appropriateness of each item.	The Bush's consists of 105 descriptive statements to be rated by parent or teacher. Eighteen scales are measured Excessive...self-blame, anxiety, withdrawal, dependency, suffering, sense of persecution, aggressiveness, and resistance. Poor...ego strength, physical strength, coordination, intellectuality attention, impulse control, reality contact, sense of identity, anger control, and social conformity.
Carolina Record of Infant Behavior (CRIB) University of North Carolina	0 - 3	10		N.A.	X	X		X				Research edition only available. One of the few infant behavior tests.	This test represents an attempt to modify the Bayley Behavior Test to make it useful in assessing infants.
Child Behavior Checklist Achenbach (1988) University of Vermont	2 and up	30 to 40	TR = .87 to .89 Interparent Correlations = .87 to .74			X		X				Demonstrated that groups identified as disturbed had significantly higher behavior problem scores than did normal comparison groups. Over controlled (internalizing) and under controlled (externalizing) syndromes have been validated.	The Child Behavior Checklist is designed to record in a standardized format the behavioral problems and competencies of children. The checklist can be self-administered or administered by an interviewer. Separate editions of the profile are standardized for each sex at age 2 to 4, 6 to 11
Joseph Pre-School and Primary Self-Concept Screening Test (1979) Stoelting Co.	3-1/2 to 9	7	TR = .87 SH = .59 - .81	N.A.		X		X	X	X		Concurrent validity = .66 with Stesson, .69 with YMI.	This test contains 15 items which asses self concept. May be used as a screening or diagnostic instrument with handicapped preschoolers. Easy to administer and score
Test of Early Social-Emotional Development (TOESD) (1984). Pro-Ed	3 - 8	30 - 50	TR = .70 - .85			X		X	X			Concurrent validity. Correlates well with other behavior measures.	The TOESD is composed of 4 components: (1) a student rating scale, (2) a teacher rating scale, (3) a parent rating scale, and (4) a sociogram. Recently normed and provides percentiles and standard scores.

(TR) = Test-retest (SH) = Split-half (AF) = Alternate Form (IR) Inter-Rater (SEm) = Standard Error of Measurement

SELECTED ADAPTIVE - SELF HELP ASSESSMENT DEVICES

ASSESSMENT DEVICES	AGE RANGE	TIME IN MINUTES TO ADMINISTER	RELIABILITY	MEAN & SD	TYPE							VALIDITY	PURPOSE / DESCRIPTION / COMMENTS
					CRITERION	NORMATIVE	GROUP	INDIVIDUAL	VERBAL	NON-VERBAL	SCREENING		
Adaptive Performance Instrument (API) (1980) Office of Special Education and Rehabilitation Services	0 - 9	Open	No Data	N. A.	X			X		X			The API measures functional skills in severely and multiply handicapped infants and young children. Assesses 8 domains: (1) Physical Intactness, (2) Reflexes and Reactions, (3) Gross Motor, (4) Fine Motor, (5) Self Care, (6) Sensorimotor, (7) Social, and (8) Communicason. Computer assisted scoring.
Scales of Independent Behavior (SIB) (1984). DLM Teaching Resources	Birth - up	60 to 75	TR/IR = .74 to .94			X		X	X			Correlations between the SIB and and Woodcock Johnson Cognitive area = .71 to .92.	This test consists of four adaptive behavior clusters: Motor Skills, Social and Communicason Skills, Personal Living Skills, and Community Living Skills. The Early Development Scale provides a developmental measure of adaptive behavior from infancy to three years.
Vineland Adaptive Behavior Scales (1984). American Guidance Service (AGS)	Birth to 18 years 11 months	20 to 30	Communication = .73 - .94 Daily Living = .83 - .92 Socialization = .78 - .84 Motor Skills = .70 - .95	$\bar{X}$ = 100 SD = 15		X		X				Median correlations between the Vineland and the Adaptive Behavior Inventory = .58, between Vineland and the AAMD Adaptive Behavior Scale = .40 to .70.	The scale assesses an individual's performance on the Daily Activities required for personality and social self sufficiency. The scale assesses four domains: (1) communicason, (2) Daily Living, (3) Socializason, and (4) Motor Development.

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APPENDIX III

Glossary[1]

Achievement Test. A test that measures the extent to which an individual has acquired certain information or mastered certain skills.

Aptitude. A combination of abilities and other characteristics, whether genetic or acquired, known or believed to be indicative of a child's ability to learn in some particular area.

Assessment. "Ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility to identify (i) the child's unique needs; (ii) the family's strengths and needs related to development of the child; and (iii) the nature and extent of early intervention services that are needed by the child and the child's family" (P.L. 99-457 Regulations, Section 300.322).

Child Find. A series of public awareness efforts designed to alert the community at-large to the availability of and rationale for early childhood intervention programs and services.

Criterion-Referenced Test. A test that measures a specific level of performance or a specific degree of mastery.

Developmental Assessment. Standardized tests that are intended to document the emergence of a sequence of behaviors, skills, or abilities over a period of time.

Diagnostic Evaluation. An examination used to ascertain conclusively whether a child has special needs, to determine the nature of the child's problems, and to suggest the cause of the problems and possible remediation strategies.

Etiology. The cause or origin of a handicapping condition.

Evaluation. "Procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility for services" (P.L. 99-457 Regulations, Section 300.322).

Incidence. The frequency of occurrence of a problem at a particular point in time.

Individualized Family Service Plan (IFSP). A statement of the family's strengths and needs related to enhancing the development of the family's child, including specific statements about outcomes, criteria, and timelines regarding progress, specific services, provisions for case management, and dates for initiation, duration and reevaluation of service.

Multidisciplinary Assessment. An evaluation of a child's strengths and weaknesses from a variety of professional vantage points using a number of different sources of information, and involving the child's parents. Typically, the child's present levels of physical, neurological, cognitive, speech and language, psychosocial development, and self-help skills are assessed.

Norms. Statistics that describe the test performance of specified groups, such as children of various ages or handicapping conditions in the standardization sample of a test.

Prevalence. The number or proportion of individuals in a community or population with a given condition or problem.

Psychometric Test. Quantitative assessments of an individual's psychological and other developmental traits or abilities.

Readiness Test. A test that measures the extent to which a child has acquired certain skills or information for successfully undertaking some new learning activity.

Reliability. The extent to which a test is consistent in measuring whatever it measures; dependability, stability, relative freedom from errors of measurement.

Screening. A brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment. Screening is designed to help children who are at risk for health and developmental problems, handicapping conditions, and/or school failure to receive ameliorative intervention services as early as possible.

Sensitivity. A statistical property of a test that indicates the proportion of those children who are at risk who are correctly identified.

Specificity. The proportion of those not at risk who are correctly excluded from further assessment or treatment.

Standardized Test. A systematic sample of performance obtained under prescribed conditions, scored according to definite rules, and capable of evaluation by reference to normative information.

Validity. The overall degree of justification for interpreting and using a test's findings. It concerns a test's accuracy. Different kinds of validity evidence are appropriate for different kinds of tests.

1. See (40), from which several of these definitions were adapted.

Screening Instruments

BIRTH TO THREE DEVELOPMENTAL SCALE

Author: T.E. Bangs & S. Dodson
Publisher: Teaching Resources
100 Boylston
Boston, Massachusetts 62116

Age Range: 0-3 Years

Areas Covered: Gross motor, fine motor, receptive and expressive language, cognitive, personal-social
Scoring: Summary score for each content area, developmental age, developmental profile

COMPREHENSIVE IDENTIFICATION PROCESS

Author: R. Reid Zehrbach
Publisher: Scholastic Testing Service
480 Meyer Road
Bensenville, Illinois 60106

Age Range: 3-5 Years

Areas Covered: Cognitive/verbal, fine motor, gross motor, speech and expressive language, social/affective, hearing and vision
Scoring: Pass, evaluate, refer, rescreen

DELRIO LANGUAGE SCREENING TEST

Author: A. Toronto, D. Leverman
Publisher: National Educational Publishers, Inc.
P.O. Box 1003
Austin, Texas 78767

Age Range: 3-7 Years

Areas Covered: Receptive Language
Scoring: Subtest totals
Other: Spanish and English

DENVER DEVELOPMENTAL SCREENING TEST (DDST)

Author: W.K. Frankenburg & J.B. Dodds
Publisher: Lodoca Project & Publishing Foundation
East 51st Avenue & Lincoln Street
Denver, Colorado 80216

Age Range: 1 Month to 6 Years

Areas Covered: Personal-social, fine motor-adaptive, language and gross motor development
Scoring: Developmental levels. Items scored as passed, failed, refused or no opportunity

DEVELOPMENTAL ACTIVITIES SCREENING INVENTORY II (DASI-II)

Author: Rebecca Fewell & Mary Beth Langley
Publisher: PRO-ED
5341 Industrial Oaks Boulevard
Austin, Texas 78735

Age Range: 0-5 Years

Areas Covered: Cognitive, fine motor
Scoring: Summary area scores, developmental age
Other: Can be adapted for use with visually impaired and has been used successfully with multiply handicapped children

DEVELOPMENTAL INDICATORS FOR THE ASSESSMENT OF LEARNING (DIAL)

Author: C. Mardell & D. Goldenberg
Publisher: Childcraft Education Corporation
20 Kilmer Road
Edison, New Jersey 08817

Age Range: 2 Years 6 Months to 5 Years 6 Months

Areas Covered: Gross motor, fine motor, concepts, communication and social-emotional level

DEVELOPMENTAL PROFILE

Author: G.D. Alpern & T.J. Boll
Publisher: Psychological Development Publications
7150 Lakeside Drive
Indianapolis, Indiana 46278

Age Range: 6 Months to 12 Years

Areas Covered: Gross motor, fine motor, receptive and expressive language, cognitive, self-help, personal-social
Scoring: Summary score for each content area, overall IQ, developmental age, developmental level
Other: Individually rated from direct observation or parent interview

DEVELOPMENTAL SCREENING INVENTORY

Author: H. Knobloch, B. Pasamanick & E.S. Sherard
Available From: Division of Child Development
Department of Pediatrics
Ohio State University College of Medicine
Columbus, Ohio 432??

Age Range: 1-18 Months

Areas Covered: Gross motor, fine motor, receptive and expressive language, cognitive, self-help, personal-social
Scoring: Summary score for each area, developmental age

ELIOT-PEARSON SCREENING PROFILE

Author: Samuel J. Meisels
Available From: Eliot-Pearson Department of Child Study
Tufts University
Medford, Massachusetts 02155

Age Range: 4 Years 6 Months to 5 Years 6 Months

Areas Covered: Perceptual, motor and language

HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT (HOME)

Author: B. Caldwell and R. Bradley
Publisher: Center of Child Development and Education
University of Arkansas at Little Rock
33rd & University
Little Rock, Arkansas 72204

Age Range: 0-3 Years, 3-6 Years

Areas Covered: Frequency and stability of adult contact, amount of development and stimulation, need gratification, emotional climate, avoidance of restriction on motor and exploratory behavior, types of play materials available
Scoring: Verbal report of parents and direct observation

INFANT TEMPERAMENT QUESTIONNAIRE

Author: W. Carey & S. McDevitt
Available From: Department of Educational Psychology
Temple University
Philadelphia, Pennsylvania 19122

TODDLER TEMPERAMENT QUESTIONNAIRE

Author: Dr. Fullard

Age Range: 4-8 Months, 1-3 Years

Areas Covered: Nine temperamental characteristics
Scoring: Easy, difficult, slow to warm up categories

MANUAL OF DEVELOPMENTAL DIAGNOSIS: THE ADMINISTRATION OF THE REVISED GESELL AND AMATRUDA DEVELOPMENTAL AND NEUROLOGIC EXAMINATION

Author: Hilda Knobloch, B. Pasamanick, et al
Publisher: Harper and Row
Hagarstown, Maryland 21740

Age Range: 4 Months to 72 Months

Areas Covered: Adaptive (cognitive, perceptual problem solving), gross motor, fine motor, language and personal-social
Scoring: Estimates of developmental maturity

MAXFIELD-BUCHOLZ SCALE OF SOCIAL MATURITY

Author: K. Maxfield & S. Bucholz
Available From: American Foundation for the Blind
15 West 15th Street
New York, New York 10011

Age Range: 0-5 Years

Areas Covered: Self-help, personal-social
Scoring: Overall summary score
Other: Is for visually impaired children, an adaptation of the Vineland

MILANI-COMPARETTI MOTOR DEVELOPMENT SCREENING TEST

Author: Revision by Meyer Children's Rehabilitation Institute
Available From: Meyer Children's Rehabilitation Institute
University of Nebraska Medical Center
Omaha, Nebraska 69131

Age Range: 0-2 Years

Areas Covered: Gross motor
Scoring: Summary score, developmental profile
Other: Administered by a physician, therapist or nurse

MILLER ASSESSMENT FOR PRESCHOOLERS

Author: Miller
Available From: KID Foundation for Knowledge in Development
1901 West Littleton Boulevard
Littletown, Colorado 80120

Age Range: 2 Years 6 Months to 5 Years 6 Months

Areas Covered: Sensory, motor, cognitive and combined complex abilities
Scoring: Individual item scores, percentile ranks

MINNESOTA CHILD DEVELOPMENT INVENTORY

Author: H. Ireton & E. Thwing
Publisher: Behavior Science System
5701 Hawkes Terrace
Minneapolis, Minnesota 55436

Age Range: 1-6 Years

Areas Covered: Gross motor, fine motor, receptive and expressive language, self-help, personal-social, situation comprehension
Scoring: All report items, summary score for each content area, developmental profile
Other: Parent fills out questionnaire

NORTHWESTERN SYNTAX SCREENING TEST

Author: L. Lee
Available From: Dr. Laura Lee
Northwestern University
Evanston, Illinois 60201

Age Range: 1-6 Years, 6-10 Years

Areas Covered: Receptive and expressive language
Scoring: Percentile ranks

PORTAGE GUIDE TO EARLY EDUCATION

Author: Portage Preschool Project
Publisher: CESA 12
Box 564
Portage, Wisconsin 53901

Age Range: 0-6 Years

Areas Covered: Cognitive, self-help, motor, language and socialization
Scoring: Developmental levels
Other: Skills are referenced to cards which describe how to teach the skill assessed

PRESCHOOL LANGUAGE SCALE

Author: I.L. Zimmerman, U.G. Steiner, C.L. Evatt
Publisher: Charles E. Merrill
Columbus, Ohio 43216

Age Range: 1-6 Years

Areas Covered: Auditory comprehension, verbal ability
Scoring: Developmental ages

SEEC MINIWHEEL AND MAXIWHEEL OF DEVELOPMENTAL MILESTONES

Author: J. Swanson
Available From: Early Childhood Education
804 West Bode Road
Schaumburg, Illinois 60194

Age Range: 0-5 Years

Areas Covered: Gross motor, fine motor, expressive language, cognitive, personal-social
Scoring: Each item evaluated individually
Other: Observational tool, items derived from Piaget

ASSESSMENT OF PRESCHOOL CHILDREN

	MOST INTENSIVE	LESS INTENSIVE	LEAST INTENSIVE
INTACT COMPONENT			
Cognitive Development	Bayley Brazelton Griffiths Hiskey-Nebraska KABC McCarthy Merrill-Palmer Stanford Binet WPPSI	Columbia Leiter PTI Raven's	Alpern-Boll Minnesota CDI PPVT Slossen Intelligence Test
Hearing	Audiological Otological	Amplaid Beltone Audiometric Maico Puretone Audiometric Seiko	Whispered Voice Test
Vision	Complete Opthalmological	Keystone Orthorater Telebinocular Titmus	Acuity, Binocular Massachusetts Snellen E Chart Strabismus
DISCREPANCY COMPONENT			
Capacity/Achievement	ABACUS Battelle Brigance UPAS Woodcock-Johnson	ABACUS-Pass II Comprehensive Identification Process Developmental Indicators in the Assessment of Learning	ABACUS Pass I Behavior Characteristics Progression Denver Developmental Screening Test
Psychological Processes:	(c.f. Cognitive Measures for Specific Subtests)		
Attention	Animal House DAS: Visual Search		Observational Data
Memory	KABC McCarthy		
Visual Perception	Bender-Gestalt CAT ITPA	VMI	
Auditory Perception	ITPA		
Thinking	ITPA	Boehm Test of Concept Formation	
Problem Solving	Picture Arrangement Comprehension		
Concept Formation	Brackew Basic Concept Scale		

PLANNING GUIDE GRID

	MOST INTENSIVE	LESS INTENSIVE	LEAST INTENSIVE
Language	ITPA		
Comprehension	Carrow PPUT	ABACUS PLS SICD	
Production	Language Sample	ABACUS PLS SICO	
Integration	ITPA		
Phonology	Templin-Darley		
Morphology	Carrow ELI		
Syntax	Northwestern		
Semantics	Mecham WPPSI/Binet		
Pragmatics			Observation Checklists
Social Perception		ABACUS Goralnick (N=54) CAT Michigan Pictures Drawings	
DEVIATION COMPONENT			
Socialization	AAMD Adaptive Behavior Scale Scales of Independent Behavior Vineland	Behavior Checklists	Anecdotal Records Directed Observation

Jeanne McRae McCarthy, Ph.D.

APPENDICES

A Planning Guide Grid

B Interagency Agreements

C NDECTS Eligibility Criteria

D Authorization Form

E Developmental History

F Public Awareness Sheet

G Master Screening Schedule

H Parent Confirmation Letter

I NDECTS Preschool Screening Folder Cover Sheet

J NDECTS Health and Wellness Record

K NDECTS 3-5 Screening Profile

L Income Inspection Form

M Parent/Child Interaction Observation Form

N Scoring Decision Guide

O Screening Results Report

P Sample Letters to Parents

Q NDECTS Referral/Request for Information

IMPLEMENTATION PREP ACTIVITY	PRIMARY RESPONSIBILITY	FISCAL RESPONSIBILITY	TRAINING NEEDS	MATERIAL NEEDS	PROCEDURE	DOCUMENTATION
I. REFERRAL						
a.) NDECTS	Regional Tracking Coordinator:			NDECTS Referral/ Authorization Form	Children on tracking who fail IMQ's or turn 36 mo. are put on screen list.	NDECTS participation indicates a need for on site screen. NDECTS Coordinator transfers child info to screening team.
b.) Agency					Agency determines child to be at-risk. Refers to tracking.	formal referral to NDECTS is completed. Agency member notifies NDECTS and screening team of child.
c.) Parent				Developmental History, telephone interview format.	Parent calls team member, intiates screen appointment.	Team member verifies a need for child's screening via developmental history, telephone interview.
d.) Advertisement				Posters, radio, newspaper ads, TV, etc.	Media blitz notifies public/ advertises for walk-ins.	Public notice of screening 1 month in advance.
						State-wide child find efforts heighten public awareness of screenings at local level.
II. APPOINTMENTS						
a.) Master Schedule	Local Screening Coordinator:			Envelopes, paper, postage, appointment & screen sched.	Appointment secretary schedules by phone. Allow 1½ hr. per child.	Complete appointment schedule.
b.) Confirmation Parent				Parent letter/Developmental History Form	Mail 1 wk. prior to screening.	Notation on child profile of date parent letter was mailed.
c.) Confirmation Staff				Photo copy of appointment schedule	Distribute to screen team prior to screening	Screen team member receives copy of appointment schedule prior to screening day.
d.) Child's File				Standard-sized file, child profile, health record, folder coversheet, author-zation form, income verification.	Child's file is organized; may include previous info gathered by tracking coordinator.	Child's file is readied for screening
III. SITE ARRANGEMENTS						
a.) Arrangement Agreements				Location with access-ability, child-sized furniture, quiet and unin-terrupted setting, multiple rooms	Yearly schedule is secured with location site. Rental agreements are signed.	Tracking team notified of screen-sites/dates for year.
b.) Screening Site Set-Up					Screening coordinator over-sees table, equipment set-up, room posters, staff material needs, coffee/treats.	Screening site prepared prior to children's arrival. Team members may bring individual tools and equipment.
IV. TRANSPORTATION ARRANGEMENTS (optional)						

continued on next page

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PREP ACTIVITY	PRIMARY RESPONSIBILITY	FISCAL RESPONSIBILITY	TRAINING NEEDS	MATERIAL NEEDS	PROCEDURE	DOCUMENTATION
IV. TRANSPORTATION ARRANGEMENTS						
a.) Agreements					Provision of transportation will be addressed through team inter-agency agreements.	Inter-agency agreement for reimbursement of transportation costs.
b.) Scheduling					Appointment schedule allows for segments of children residing in close proximity.	Appointment schedule denotes children who need ride to screening.
c.) Child-Parent				Vehicle/driver	Child/parent is transported to/from screening by designated agency.	Transportation occurs in timely and cost efficient manner.

V. SCREENING ACTIVITY	PRIMARY RESPONSIBILITY	FISCAL RESPONSIBILITY	TRAINING NEEDS	MATERIAL NEEDS	PROCEDURE	DOCUMENTATION
REGISTRATION				Indvidual child's file.	Parent/child are greeted, signed in, given nametag and escorted to first station. Walk-ins will complete developmental history form. Results of this determine need for screening.	Check-off on appointment schedule. Parent signature is witnessed on on authorization form. Walk-ins are recorded, put on screen list if need is verified, child's file started
FAMILY HISTORY				Developmental History Form	If not complete, parent instructed to do so, assisted if needed.	All items on developmental history are answered, form is placed in child's file.
VISION						Protocol sheet completed, placed in file. Results indicated on folder coversheet. Screener(s) sign off on coversheet.
HEARING						
HEALTH/DENTAL				Immunization record, growth chart		
COGNITIVE				Screening protocol, tools:		
MOTOR a.) Fine b.) Gross				Screening protocol tools:		
SPEECH/LANGUAGE a.) Expressive b.) Receptive				Screening Protocol tools:		
PARENT EXIT CONFERENCE				Parent information packets	Staff member reviews child's performance, answers parent questions, summarizes standard follow-up procedure.	Check-off on folder coversheet, include parent comments and/or request for further information.
SCREENING TEAM STAFFING a.) Indvidual child Reports				Child's file	Exit conference staff member leads team discussion. Review of each child, reach consensus re: recommendations.	Team recommendations recorded on 3-5 child profile shee, using the Decision Code 1-5. Child's screening scores are recorded on 3-5 child profile sheet using score code, based on TEAM discussion and decision.
b. Screening Tracking Team Business				Minutes of team business meeting.	screen team deals with procedural issues, communicates with tracking team members.	Minutes of team business/over-all screening summaries are given to tracking coordinator for distribution at next tracking team meeting.

FOLLOW-UP ACTIVITY	PRIMARY RESPONSIBILITY	FISCAL RESPONSIBILITY	TRAINING NEEDS	MATERIAL NEEDS	PROCEDURE	DOCUMENTATION
. RECORD KEEPING				Child's file, screening forms, folder checklist.	Screening coordinator verifies that scores from screening protocol sheets were entered on child profile sheet.	All records complete and properly filed. Folder checklist complete.
					Screening coordinator reviews team recommendations for each child and prepares appropriate correspondence to be used in explaining this to parents, agencies and tracking team.	Children's files are housed within agency previously designate through screen team agreement. Access to those files will be open to any team member.
I. CORRESPONDENCE						
a.) PARENT LETTER				Envelopes, paper, postage, individualized form letter to report staffing screening results, team recommendation.	Letter is completed and mailed to parent within reasonable time period of screening, summarizing results and recommendations of the team.	cc of letter placed in child's file
b.) CC TO AGENCY						cc sent to referral agency(s) when appropriate.
c.) NDECTS REFERRAL TO OTHER AGENCY				NDECTS Referral/Request for Information Form or locally devised format.	If screen team recommends a referral of child to another agency for follow-up, contacts with that agency are made and verified with the parent.	Referral completed to other agency and results returned to NDECTS.
d.) DATA REPORTING TO TRACKING TEAM				Composite screening summary	Summary is completed reflecting child's screen scores/team recommendations, follow-up status.	Summary composite shared at tracking team meeting. Recorded with team minutes.
					Tracking team reviews results of screening, may make additional recommendations for individual child.	Tracking project coordinator receives screening information necessary for on-going data management.
I. DATA MANAGEMENT RECORDING			Computer data entry procedures	Computer, data management software		
a.) SCREEN RESULTS					Screening scores and team recommendations recorded by computer.	Screening summary stored on data disc.
b.) CHILD UP-DATE					Monthly lists reflect child's re-screen date, reminder to team.	Tickler list is generated each month, shared with screen team.
c.) LOCAL/STATE REPORTS					Monthly aggregate reports to DPI reflect #'s of children on tracking. Periodic child count reports are generated for local special ed. units.	Regional Tracking Coordinator reports to DPI #'s of children on tracking.

INTERAGENCY AGREEMENTS

WRITING INTERAGENCY AGREEMENTS FOR PRESCHOOL SELECTIVE SCREENINGS

The composition of an interagency agreement can vary depending on the purpose and complexity of the collaborative effort. When creating interagency agreements for selective screenings, authors can exercise considerable latitude in the structure and content of the agreements. Although agreements may vary, depending on the unique service delivery structure within an area, agreements might benefit, nonetheless, from the inclusion of some key components (Elder and Magrab, "Coordinating Services to Handicapped Children: A Handbook for Interagency Collaboration"; 1980).

I. Components of Interagency Agreements.

The following listing of components highlights those issues one might encounter during discussions with a variety of agencies and providers. Remaining flexible and adapting to the unique configuration of services in an area will allow agreements to attain their optimum value as agents of growth. Agreements are both a means to and a result of interagency collaboration. As the entire collaborative endeavor matures, so too does the agreement which codifies that collaboration.

A. Participating Agencies.

Within North Dakota a variety of agencies and organizations provide screening opportunities to a broad or selective population of preschool children. Some providers offer screenings on a for profit basis. Other organizations provide screenings as a part of their charitable outreach mission. Still other agencies, as the local special education units, provide screenings by federal mandate.

Local special education units hold an important position in fostering local interagency collaboration. By inviting the participation of other agencies and providers into a unified screening effort, an efficient, mutually satisfying arrangement can result.

Among the first issues to consider is who might benefit from inclusion as a participant on the screening team. Potential team members include the North Dakota Early Childhood Tracking System, Special Education, Public Health, Head Start, WIC, medical centers, charitable organizations (e.g., Shriners, Optimist Club, Elks, etc), university based services, among others. Efforts might be made to assure all relevant parties have been informed of the screenings and invited into discussions concerning their possible role. Because of its federal mandate, the special education unit would act as lead agency overviewing the coordination and conduct of the screening.

The interagency agreement would explicitly list those agencies entering into a collaborative effort to conduct these selective screenings.

B. Statement of Purpose.

The statement of purpose is a clear, concise statement which summarizes the intent of the selective screening process. This statement might outline the goals and measurable objectives of the collaborative effort.

An example of this statement might include: "It is the purpose of this agreement to offer unified, interagency screening opportunities to preschool children at-risk for developmental delays. These screenings are designed to assess children's current level of performance in the following skill areas: vision; hearing; health; dental; expressive and receptive language; gross and fine motor; cognitive; adaptive; and personal social. It is further the purpose of this agreement to offer to the families of these children recommendations for services should their children prove to be eligible. It is the intent of all participating agencies to contribute their resources and expertise as delineated below to accomplish these aims."

C. Definition of Terms.

This section attempts to clarify and adopt a common usage of language. Many disciplines and agencies utilize their own specialized terminology which may result in confusion and reduced cooperation within an interagency team. Before developing further the specifics of the agreement, this section defines those terms used within the agreement that require the clear understanding of all parties. Terms such as "screening", "assessment", "evaluation", "services", "monitor", "tracking", among others, require a uniform definition agreeable to all parties.

D. Program Foundations.

The Program Foundations section summarizes the philosophical and legal reasons leading to the creation of a particular interagency agreement. This section briefly (1) outlines the collective motivations and intentions of all parties cooperating in this joint venture, and (2) states the legal precedents supporting the need for such collaboration.

Interagency agreements at the local level find their foundation, either explicitly or implicitly, in precedent setting federal or state agreements. Establishing direct connections with these earlier documents strengthens the legitimation of a local agreement in particular and offers authority for interagency collaboration in general.

Special education units may state or allude to a growing body of authoritative documents:

1. NDCC 15-59-05.2. The Department of Public Instruction is to foster interagency cooperative agreements for the provision of educational related services to handicapped children.

2. 20 USC 1413(a)(1); 34 CFR 300.148. Federal Part B funds may be used to continue supporting child identification, location and evaluation activities.

3. North Dakota Annual Program Plan for FY 1990-92, EHA-B. (NDAPP) II(C). The process of assessment is to benefit as much as possible from team effort. Appropriate exchange of information between agencies should optimize identification of children with risk factors for handicapping conditions.

4. 20 USC 1412(2)(C); 34 CFR 300.128. The local education agency is the central referral point for information regarding identified handicapped children. A screening plan will be prepared to assure that, cooperatively with other agencies, preschool screening is available.

5. NDAPP (III)(A). An early childhood tracking system for monitoring children, ages 0-5, has been developed through an interagency effort. The system will assist with early identification of children in need of a wide range of services including special education.

6. NDAPP (III)(B). The North Dakota Interagency Coordinating Council will initiate interagency agreements to facilitate child identification.

7. NDAPP (III)(C). The state commends exemplary preschool projects and interagency cooperation providing ongoing evaluative and programming services, including preschool screening with public health services, human services, and private/nonprofit organizations to provide more complete nonduplicated screening services for children.

8. Statement of Interagency Collaboration, February 11, 1987. The North Dakota Departments of Health, Human Services and Public Instruction agree to efficiently utilize interagency programming which impacts handicapped children and their families.

   Many government agencies possess similar authority or encouragement to enter into interagency agreements in the conduct of their respective programs. For charitable organizations such collaboration is implicit in their organizational charters with ample latitude left to the discretion of the organization's officers. It is beneficial for all participating agencies to outline the principles which ground their involvement in the selective screening process. These expressed principles deepen the investment of all parties to the inherent value of collaboration and to the improved service offered each child and family.

E. Roles and Responsibilities.

This section details which duties each participating agency is responsible for accomplishing. Questions concerning publicity, transportation, referrals, intake, processing, screening stations, tools, post-screening staffing, exit interviews, and more need to be clearly delineated to avoid any misunderstandings. Each duty might be listed and accompanied by the name of the agency and person responsible for the accomplishment of the task.

Also included in this section is a listing of the names and positions of representatives from each agency designated to assure that (1) the agreement is implemented as specified, and (2) the agreement is evaluated and renegotiated when it is appropriate to update it. This will ensure the vitality of the agreement and secure the continuity of the entire collaborative effort.

F. Financial Responsibility.

This section specifies the financial obligation, through outlay or contribution, each participating agency absorbs for participating in the selective screening program.

The special education unit by federal mandate is financially responsible for the offering of selective screening opportunities in order to locate and identify handicapped children eligible for services; however, other agencies have similar mandates to offer screenings for other specific concerns. Public health units screen for health concerns by mandate of their Title V grants. Head Start offers screenings for development by mandate of their authorization grants. Some charitable organizations offer vision and orthopedic screenings or transportation and contributory services by mandate of their organizational charter. Although special education units hold final financial obligation for selective screenings, accessing these other sources may lessen special education's ultimate outlay.

An interagency agreement might itemize each agency's financial and/or service contributions. The financial contributions of agencies, excluding special education, may be considered as first dollar responsibilities of these agencies. Their money is first to pay for the screenings up to a limit agreed upon by all parties. The financial contributions of special education may be considered as last dollar responsibility. Special education will pay for those expenses which remain uncovered. If an agency commits no money outright but contributes through the commitment of personnel to the screening effort, these contributions should be specified; further, it may prove beneficial to attach a dollar amount to these contributory services.

As funding becomes tighter, the financial collaboration of agencies become more imperative. An interagency agreement, in addition to improving communications and the quality and coordination of services, optimizes the limited financial resources available for screening services.

G. Administrative Procedures.

This section outlines the policy concerns inherent in interagency collaboration and postures the agreement for possible future collaboration.

This section differs from the Roles and Responsibilities section by the scope of its issues. The Roles and Responsibilities section specifies the duties each agency assumes for the selective screening session itself, e.g., who will staff the speech and language station. The Administrative Procedures section outlines policy issues, such as, what is the specified starting and ending date for the agreement, how and when might the agreement be revised, how shall information be shared among agencies, what confidentiality safeguards will be employed, what uniform referral process will be used, who will act as coordinating agency, what are the nondiscriminatory clauses, what is the evaluation procedure for the selective screening process and the agreement, among others.

Interagency agreements may be written in any format and with varied content in order to meet the specific needs of a community. The above components are offered as building blocks for a wide variety of circumstances. As team participants meet to disucss their tasks, the agreement will develop into its own unique form. The value of an interagency agreement might not be judged so much on its sophistication as on its ability to call agencies together in the service of families and children. To the extent that a child has been served in the most effective manner, there lies the value of interagency collaboration.

II. Examples of Interagency Agreements.

The following pages illustrate different types of interagency agreements. These agreements are offered as examples on how an agreement might be structured. If you desire additional resources, contact the Special Education Division, Depart menht of Public Instruction for other examples.

Agreement Between the Crippled Children's Division, University of Oregon Health Sciences Center, Oregon State System of Higher Education and the Creswell School District #40

I. STATEMENTS OF GENERAL RESPONSIBILITY

A. The Crippled Children's Division (CCD) is responsible for the administration of a program to extend and improve services for locating crippled children and for providing medical, surgical, corrective, and other services and care facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions which lead to crippling.

B. The Creswell School District #40 (CSD) is responsible for providing services and facilities, including but not limited to, curriculum material, special teachers, and special programs for handicapped children who reside in the CSD.

II. STATEMENT OF PURPOSE

It is the purpose of this agreement to provide arrangements for physical therapy services to physically handicapped students who reside in the CSD.

III. STATEMENTS OF SPECIFIC ROLES AND RESPONSIBILITIES

A. The CCD will provide a part-time registered physical therapist ten hours a week (.25 FTE) who will be a salaried employee of CCD. This person will provide physical therapy evaluations, consultation, and treatment to physically handicapped students in the CSD.

B. The staff of the CCD regional office in Eugene will provide medical direction and therapy supervision and coordination to the physical therapist hired under this agreement in the performance of the service function. Medical direction will consist of an annual chart review of all physically handicapped students residing in the CSD and provision for prescription of physical therapy services by a licensed physician. Physical therapy supervision and coordination will consist of an annual chart review of all physically handicapped students residing in the CSD and consultation as needed by a supervising physical therapist.

C. The CCD will provide equipment and supplies for students that may be required by the physical therapist in performance of the service function.

D. The CCD will provide in-service training opportunities for the physical therapist through attendance at regional physical therapy/occupational therapy meetings.

E. The CCD will provide suitable office space and office supplies for the physical therapist in the Clinical Services Building on the University of Oregon campus.

F. The CSD will provide:

1. Program supervision to include, but not limited to, management of time, communication with staff and parents, and
2. Job related travel reimbursement for the physical therapist.

IV. FINANCIAL CONSIDERATIONS

The CSD will pay to CCD upon billings from CCD the basic salary and fringe benefits of the physical therapist in the amount of $2,522 for salary and $681 for fringe benefits. This payment will be made no later than December 31, 1979. The CSD will pay to CCD upon billings from CCD for the cost of providing medical and physical therapy supervision in the amount of $25 per hour for medical supervision and $12.50 per hour for physical therapy supervision. The maximum amount CSD will pay for this supervision will not exceed $375. The CSD will also pay to CCD upon billings from CCD for the cost of student equipment and supplies. The maximum amount CSD will pay for such equipment and supplies will not exceed $88. The final billing from CCD to CSD for supervision, equipment, and supplies will be submitted no later than 15 days after the ending date of this agreement.

V. ADMINISTRATIVE CONSIDERATIONS

A. This agreement will take effect as of October 1, 1979, and will continue in effect until June 30, 1980.

B. The terms of this agreement may be modified during the time period mentioned above if both parties mutually agree to suggested changes.

C. Both parties to this agreement will comply with confidentiality requirements of state and federal law to ensure the confidentiality of individual client data.

D. The individuals occupying the following positions in each agency will be responsible for 1) implementing this agreement as specified, 2) monitoring the implementation, and 3) negotiating change when necessary to update agreement

1. CCD—Director, Regional Services Center, Eugene
2. CSD—Director of Special Education

OREGON STATE BOARD OF HIGHER EDUCATION
on behalf of the
UNIVERSITY OF OREGON HEALTH SCIENCES CENTER.
Crippled Children s Division

by (Signed)
Director, CCD
Date 11/5/79

by (Signed)
Business Manager, UOHSC
Date 11/29/79

CRESWELL SCHOOL DISTRICT #40

by (Signed)
Superintendent
Date 10/25/79

Interagency Agreement
Outline for Roles and Responsibilities

OBJECTIVES

I. CHILD IDENTIFICATION

- Child Find/Referral
- Screening
- Evaluation/Eligibility

II. INDIVIDUALIZED PROGRAM PLANNING

- Case Management
- Team Planning
- Follow-up

III. PROGRAM IMPLEMENTATION, SERVICE DELIVERY

Service Delivery

- Advocacy
- Alternative Living Arrangements
- Assessment/Diagnosis
- Case Management
- Counseling
- Community Awareness
- Day Care
- Education
- Equipment
- Financial Assistance
- Health Services
- In-home Assistance: Health, Homemaker
- Investigations
- Medicine/Special Food
- Parent Training/Support
- Prenatal/Perinatal Care Resource
- Preventive Services
- Resource Material
- Respite Care
- Screening
- Transportation

IV. TRAINING

Professional

Pre-service
Inservice

Parent

V. STATE ADMINISTRATIVE RESPONSIBILITY

Licensing

Facilities
Personnel

Compliance Monitoring

ROLES AND RESPONSIBILITIES

bjectives	Special Education	NDECTS	Infant Development	MCH	Headstart
ILD IDENTIFICATION ild Find Locate students in need of services	Provides awareness campaign for child find (primary responsibility for children suspected of handicapping conditions 0-21) Coordinates this activity with other agencies Refers to tracking and other agencies as appropriate e.g. 0-5 screening, evaluation of suspected health, medical condition. (FR-Statewide, special education is the primary agency for child find activities.)	Facilitates awareness thru Interagency Team contacts Provide printed material at agency sites Serves as a central point of referral for at-risk, 0-5 Provides parent awareness material/information Makes referrals based on information from families and participating agencies Fiscal responsibility: Primary responsibility for coordinator of tracking activities	Infant Development - no primary responsibility for child find activities. Accept and act on referrals from other agencies.	The State Health Department established priorities for the expenditure of Title V Funds by local health units. The Department gives local health units authority to use Title V Funds to carry out programs aimed at the early identification of children with handicapping conditions. Referral to appropriate agencies is an approved service. The State Health Department offers a toll-free 800 number statewide to anyone with health related concerns.	Child Find - Provides a parent and agency's public awareness campaign during the spring and summer of each year for eligible children. Ten percent of the identified children must be children with disabilities according to 94-142. Headstart has been given permission to serve ten percent over the income guidelines. Refer Headstart children to other appropriate agencies i.e. Interagency teams, local special education units, the broader child care community. (Primary responsibility for child fund for Headstart children). All enrolled children must be screened within 45 days of enrollment. All children suspected of having a handicapped condition must be referred to the child's local public school for further evaluation. (Timeline). Screening includes developmental, speech and language, vision, hearing, nutrition, and medical. Family needs assessments are completed at this time.
creening A Preliminary determination of delays or difficulties	Provides developmental screening for children suspected of handicaps 0-5-- (FR-Payor of last resort 0-2 of children suspected of handicapping condition. Primary responsibility 3-5 suspected of handicapping condition.) Nothing under state and federal statutes (EHAB) relieves an appropriate agency from an otherwise valid obligation to provide or pay for services provided to a handicapped child or a child suspected of having a handicapping condition.	Carries out tracking monitoring thru use of parent completed questionnaires at developmental intervals, 0-2, and carries out Developmental screenings 0-5 with primary emphasis being 3-5 at intervals as determined by screen team Solicits interagency cooperation in conduct of screening activities Data management Fiscal responsibility: Primary responsibility for monitoring of participating at-risk children	Provides screening for individual referrals as part of the eligibility determination process.	The State Health Department may authorize local health units to use Title V Funds to conduct well child screenings to determine growth and general health conditions as well as developmental delays in children birth through ---?---.	

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ROLES AND RESPONSIBILITIES

Objectives	Special Education	NDECTS	Infant Development	MCH	Headstart
reening (cont.)	COMMENT: Examples of instances where payor of last resort may share in the cost of services include exceptional cost, lack of available personnel in a particular area to carry out specific assessment, and/or uniqueness of situational factors.				(Responsible to obtain screening services whether it be federal or non-federal sources. Payor of last resort.)
luation Determination of eligibility for services for handicapped or at-risk children	Provide diagnostic evaluation for referred children using appropriate instruments - 3-5 Determine existence of handicapping conditions. Refer children (3-5) who have been evaluated and are ineligible for service to tracking or other appropriate services. (Primary responsibility for costs of evaluation for 3-5 children suspected of having handicapping conditions.)	Refer children 0-5 who require evaluations to appropriate agencies Data Management	Using appropriate instruments, provide developmental evaluation for referred children birth through two years and whose third birthday falls on or before August 31. Determine existence of developmental delay. (Primary responsibility for costs of evaluation for birth-two children within program components.) Infant Development will conduct evaluations in the areas of: Gross Motor Fine Motor Communication Cognitive Social/Emotional Should an additional outside evaluation component be recommended, the ID program is not financially responsible. The I.D. personnel and DD case management personnel will assist in accessing	The State Health Department may authorize local health units to use Title V Funds to conduct nursing assessments. Results of these assessments may be used for referral to appropriate medical services or other agencies.	Headstart children suspected of handicapping are referred to appropriate agencies for evaluation. Note: Exceptions to this may be speech and language for the centers with employed speech therapists. (Payor at last resort.)

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Objectives	Special Education	NDECTS	Infant Development	MCH	Headstart
INDIVIDUAL PROGRAM PLANNING To develop individual program plans to meet assessed special needs of eligible children	To develop IEP through a multidisciplinary team process involving other agencies as appropriate based on unique needs of child ages 3-5. Identify and plan appropriate special education and related services in relation to child's unique needs and IEP program goals and objectives including where services will be delivered. Participate in development of individual transition plans for children scheduled to exit infant development program at age 3. (Primary responsibility for the IEP planning process including initiation of parent and interagency contacts regardless of primary placement.)	N/A	To develop IFP through a multidisciplinary team process involving other agencies as appropriate based on unique needs of child ages birth through two. Identify and plan appropriate intervention and related services in relation to child's unique needs and IFP program goals and objectives including where services will be delivered. Initiate and participate in development of individual transition plans for children who will reach age 3 by August 31. (Primary responsibility for the IFP planning process including initiation of parent and interagency contacts.) Note: changes will be forthcoming with advent of IFSP.	The State Health Department may authorize local health units to use Title V Funds to develop nursing care plans for individual clients or patients. These may include follow-up/follow along, health counseling, health services, home nursing, parent training/support as needed by families with young children.	Every Headstart child has an IEP. This IEP is developed through the Headstart Child Study Team based on child's unique needs. Headstart requires <u>at least</u> 2 home visits throughout the program year for parent input, development and updating of plan. The plan must include comprehensive goals and objectives to cover the child's whole development. Note: With new regulations all Headstart will be required to use LEA, IEP format.)
e Management The activities carried out by a case manager to assist and enable the child and the child's family to receive appropriate services	Provide case management coordinator function as outlined in IEP (3-5) Case Manger Role 1. Coordinating multidisciplinary evaluation; 2. Collecting and synthesizing the evaluation reports and other relevant information about a child that might be needed at the IEP meeting; 3. Communicating with parents 4. Participating in or conducting the IEP meeting		Case management functions within Infant Development programs are carried out by the <u>primary interventionist</u> or personnel designated by <u>child IFP team</u>. Case Manager Role 1. Coordinating evaluation; 2. Collecting and synthesizing the evaluation reports and other relevant information	The State Health Department may authorize local health units to use Title V Funds to provide case management/care management coordination as outlined in nursing care plans including follow-up/follow along and referral services.	Primary case management of the child's IEP is the responsibility of the child's classroom teacher. Each program is responsible to have on staff a Coordinator for disabled children to serve on the IEP team and coordinate services for that child. Case manager role - collect and synthesize all information concerning child for IEP meeting

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ROLES AND RESPONSIBILITIES

ctives	Special Education	NDECTS	Infant Development	MCH	Headstart
Management (cont.)	(Primary responsibility for 3-5 handicapped children education case manager) If case management services are necessary beyond those provided through the IEP process the family will be referred to an appropriate agency for the provision of those services, e.g. Developmental Disabilities, Crippled Children Services, the family physician, Maternal and Child Health, etc.		about a child that might be needed at the IPP meeting; 3. Communicating with parents 4. Participating in or conducting the IPP meeting itself. 5. Provide parent training using transdisciplinary approach. 6. Fulfill case managements role as prescribed in ACDD standards. (Primary responsibility for 3-5 handicapped children education case manager) If case management services are necessary beyond those provided through the IPP process the family will be referred to an appropriate agency for the provision of those services, e.g. Developmental Disabilities, County Social Services, the family physician, Maternal and Child Health, or other public health program.		Communication with parents. Conduct IEP meeting. Primary monitor of IFP activities and follow-up i.e. daily logs based on observation, weekly meeting and monthly meetings.
ow-up Provide periodic review of activities in program plan	Conduct follow-up activities as outlined in IEP-carry out monitoring of program implementation for 3-5 handicapped children. (Primary responsibility for follow-up for 3-5 handicapped children.)		Conduct follow-up activities as required by ACDD program review standards, i.e. monthly IPP reviews, including review of goals and objectives, service objectives, special equipment needs, etc. (Primary responsibility for follow-up for birth through two developmentally delayed children eligible to receive	The State Health Department may authorize local health units to use Title V Funds to provide follow-up health services to individuals based on hospital discharge plans, e.g., infants discharged from a neonatal unit. Other follow-up activities may be carried out in accordance with a nursing care plan. One of the agencies that provided follow-up activities for children and parents is the early childhood tracking	Conduct follow-up activities as outlined in IEP for identified headstart children with disabilities. Follow up is the responsibility of the Headstart component coordinators i.e. vision referral through health coordinator parenting classes through parent involvement coordinator. (Payor of last resort.)

Objectives	Special Education	MDECTS	Infant Development	MCH	Headstart
PROGRAM IMPLEMENTATION, SERVICE DELIVERY SERVICE OPTIONS Services provided by each agency	All of these services are either directly provided or contracted by the agency. Assessment/diagnosis Case Management Consultation/technical assistance Community awareness Education Equipment Health services Identification Information and referral Instructional/testing materials Parent training/support Resource material Screening Staff training Transportation Transition planning for school Child find COMMENT: If there is a duplication of service for the age group and a dispute arises, refer to resolution of dispute section.	Public Awareness Tracking Parent Information Information and Referral	All of these services are either directly provided or contracted by Infant Development. Assessment/diagnosis Case Management Consultation/technical assistance Community awareness Follow-up/follow along Education History Health services Identification Information and referral Instructional/testing materials Parent training/support Screening based on individual referrals Staff training Transition planning to preschool COMMENT: If there is a duplication of service for the age group and a dispute arises, refer to resolution of dispute section.	The State Health Department may authorize local health units to use Title V funds to provide all of the following services: Assessment (nursing) Case management Child health nursing conferences Community awareness Follow-up/follow along Health counseling Health education Health services Home nursing Identification Immunization clinics Parent training/support Prenatal/perinatal care resource Preventive services Referral Resource material Screening Staff training	Parent training/support Screening and follow-up Nutrition program Transportation Social Services Staff training and technical assistance Assessment/diagnosis Community awareness Education Health services Information and referral Meals Preventive services Resource material

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jjectives	Special Education	NDECTS	Infant Development	MCH	Headstart
AINING Activities that are provided to improve parent and/or professional skills to meet the child's needs	CSPD (Comprehensive System of Personnel Development Programs and procedures for the development and implementation of a system of personnel development which includes: A. Providing in-service training of general special ed related service and support service personnel; B. Establishing preservice training procedures to insure personnel are qualified; C. Establishing procedures for acquiring and disseminating information from educational research, demonstrations, special projects, and promising practices and materials. (Primary responsibility for CSPD plan for 3-5 personnel including other agencies as appropriate to topic.) Parents Provide inservice training to parents as it relates to provision services as outlined in the IEP. (Primary responsibility as it relates to implementing objectives in IEP).	Provide inservice training to interagency team and other groups as appropriate	ACDD requires an in-service plan for Infant Development staff which is to include topics as first aid, CPR, seizure control, behavior management. A. Providing in-service training to deal with appropriate needs of specific child. B. Establishing preservice training of a general nature in areas such as CPR, first aid, etc. Note: The Developmental Disabilities Division, Department of Human Services is responsible for dissemination of information from educational research, demonstrations, special projects, and promising practices and materials. Parents - Provide ongoing parent training as it relates to provision of services as outlined in the IPP. (Primary responsibility as it relates to implementing objectives in IPP.)	Training costs are allowable under Title V Grant regulations. The State Health Department may authorize local health units to use Title V Funds for training activities aimed at improving skills of community health personnel delivering services to children and families.	Each program requires career development activities for staff and parents. PA20-Money designated for training and technical assistance - used for comprehensive training of staff and parents. Resource access Project (RAP) serves Region VIII T.A. and provides training to staff and parents in Headstart programs in areas concerned with education of children with disabilities. Resource Service Grant (RSG) serve Region VIII for overall training needs. Programs are encouraged to include the broader child care community in their education/training components.

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ROLES AND RESPONSIBILITIES

Objectives	Special Education	NDECTS	Infant Development	MCH	Headstart
STATE ADMINISTRATIVE RESPONSIBILITY Licensing-Assurance that facilities or personnel meet established state standards, e.g. certification/ licensing/registration	Assure that handicapped students are not excluded from accessibility to an educational program based on their handicap. (Primary responsibility for 3-5 - Section 504) Local units must have contingency plans for long range educational facility planning and renovation of existing facilities.	N/A	Infant development programs will be licensed by the Department in accordance with 75-04-01, Licensing of Programs and Services for Developmentally Disabled Persons.		Assure the Headstart Programs follow requirements outlined in Federal Performance Standards as well as appropriate local/ codes. Annual program grant applications must include assurances that the program facilities comply with 504 standards.
Personnel	Assure on an annual basis that all personnel serving handicapped children ages 3-5 have met professional qualifications for their assigned duty area. (Primary responsibility for certification of pre-school handicapped teachers and assure of licensure for related services personnel.)		Infant development programs shall have the following professional competencies either on staff or available through a contract for services from professionals in the community. Professional staff will hold valid North Dakota licensure if such license is required by North Dakota law. 1. Early childhood/handicapped speciality. The following competencies may be met through the qualifications of several staff persons. These competencies are: a. Infant and child development, typical/ atypical, psychology of the exceptional child; b. Assessment, formal and informal;		Personnel policies are determined by the local grantee. Assure that personnel serving handicapped/headstart children meet certification/licensure standards.

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Objectives	Special Education	NDECTS	Infant Development	MCH	Headstart
Personnel (cont.)			c. Program implementation (behavioral management techniques, methods and curriculums, knowledge of learning theory, parent training); d. Transdisciplinary writing of goals objectives and instructional objectives; e. Home-community relations (crises intervention communication, family systems); and f. Administration, needs assessment, supervision, team process for IHP and IFP development, evaluations, internal case management. 2. Physical therapist 3. Occupational therapist 4. Speech pathologist (1) Parent trainers. Parent trainers will be directly supervised by appropriate professional staff. At times, the infant's and their families may need the services of a social worker, audiologist, hearing impaired specialist, vision impaired specialist, psychologist, public health nurse,		

Objectives	Special Education	NDECTS	Infant Development	MCH	Headstart
Personnel (cont.)			nutritionists. These services should be accessed from other service agencies without cost to the infant development program where available. Agreements should be developed with these agencies (Public Health, School for the Deaf, School for the Blind, Human Service Centers) to provide services on an as-needed basis.		
Compliance Monitoring Gathering and review of information which has as a principal objective the determination of whether each educational program for handicapped children administered within the State (including private schools in which handicapped children are placed by public agencies) meets educational standards of the SEA, EHA-B, and EDGAR			Infant Development Programs must meet the professional competencies as outlined in the Service Chapter. Monitored by ACDD		

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*use obj. 2 (b), (c), (d) from pam, **

ROLES AND RESPONSIBILITIES

Objectives	BIA Special Education				
CHILD IDENTIFICATION					
Child Find					
Screening					

NDECTS ELIGIBILITY CRITERIA

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM
ELIGIBILITY CRITERIA
REVISED 1989

MEDICAL/BIOLOGICAL RISK FACTORS

1. Gestational age less than 37 weeks, NICU graduate.
2. Low birth weight -- under 2000 grams/4.4 pounds.
3. Respiratory distress requiring mechanical ventilation greater than 24 hours.
4. Apgar score of four or less at five minutes.
5. Major congenital anomalies.
6. Delayed development of suck and swallow that persists beyond 28 days.
7. Intracranial hemorrhage.
8. Neonatal seizures.
9. Clinically known or suspected evidence of central nervous system (CNS) infection/trauma (congenital or postnatal).
10. Microcephaly/Macrocephaly
11. Hyperbilirubinemia requiring exchange transfusion.
12. Hypoglycemia -- serum glucose under 35 mg/dl.
13. Severe chronic illness or condition.
14. Maternal phenylketonuria, diabetes, hypothyroidism, and other maternal metabolic disorders critical to the infant.
15. Maternal use of anticonvulsants, antineoplastic or anticoagulant drugs during pregnancy.
16. Suspected hearing and/or vision impairment.
17. Diagnosed genetic disorder.
18. Serious congenitally or postnatally acquired infection.
19. Neonatal drug addiction or withdrawal syndrome.

DEVELOPMENTAL RISK INDICATORS

20. Evidence of growth deficiency.
21. Failure on standard developmental or sensory screening test.
22. Identified emotional/behavioral disorders.

ENVIRONMENTAL RISK FACTORS

23. Maternal age of less than 17 years.
24. Lack of routine medical care (prenatal, postnatal, preschool.)
25. Parental sensory impairment, mental retardation, learning disability psychiatric disorder.
26. Parental substance abuse.
27. Difficulty in parent-child bonding.
28. Difficulty in providing basic parenting.
29. Lack of stable housing.
30. Lack of familial and social support.
31. Significant family/socio-economic stressors
32. Abuse/neglect within household which may or maynot include the name of the child in the 640 report.
33. Significant parental concerns about the child's development.
34. Multiple-risk factors.

Adapted from: Blackman, James, M.D. Warning Signals: Basic Criteria for Tracking At-Risk Infants and Toddlers. National Center for Clinical Infant Programs, 1986.

AUTHORIZATION FORM

NDECTS AUTHORIZATION FORM
Division of Special Education
Department of Public Instruction
SFN14053 (R12/89/P2,000)

Multiple births require separate forms

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM*
AUTHORIZATION FOR PARTICIPATION

I, the undersigned, being the parent/guardian of _____,

born on _____, do hereby request the following:

1. If my child is eligible as determined by the Early Childhood Tracking Team, name and referral information will be entered on the North Dakota Early Childhood Tracking System.

2. I, as parent, will complete and return periodic questionnaires (4 months, 8 months, 12 months, etc.) regarding the growth and development of my child,

   or, I as a parent, will participate in periodic preschool screenings that will measure the status of my child's growth and development.

3. I will be notified by the Tracking System team of my child's status after review of each questionnaire/screening (whether my child's development will continue to be monitored or my child will exit the system).

4. My child's physician will be informed of our involvement in the North Dakota Early Childhood Tracking System and of any referrals or recommendations regarding my child.

5. I have the option to withdraw from participation in the Tracking System at any time.

*Agencies participating in the North Dakota Early Childhood Tracking System include the State Department of Health, the Department of Human Services and the Department of Public Instruction.

Signature of Parent/Guardian:

_____
First Middle Last (Date)

_____
Street Address/Box Number

_____
City State Zip County

Witness _____ _____
(Date)

Position _____

Agency _____

Agency Address _____

_____

Letter of explanation or brochure with authorization forms
3 copies - original to referring agency
copy to interagency team
copy to parent/guardian

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DEVELOPMENTAL HISTORY

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM
SCREENING REFERRAL/DEVELOPMENTAL HISTORY RECORD

Child's Name:_____ DOB: ___/___/___ Sex: M F
(month) (day) (year)

Street Address:_____ City:_____ State:_____ ZIP:_____

Father's Name:_____ Age:_____ Occupation:_____

Mother's Name:_____ Age:_____ Occupation:_____

Home Phone:_____ Work Phone:_____

Number of brothers and sisters:_____

HEALTH: Physicians Name:_____ Clinic:_____ Dentist:_____

Weight at birth:_____lbs._____oz. Was there anything unusual about the pregnancy with your child? NO YES If yes, explain:

Did your child require any special medical care or hospitalization at birth or the first month after birth? NO YES If yes, explain:

When was the last time your child saw a doctor?_____ Briefly what was the reason:

Does your child have any dental problems? NO YES If yes, explain:

**Does your child have an up-dated shot record? NO YES

Do you notice, or has a doctor reported, any of the following in your child?

Asthma____ Indigestion____ Constipation____ Diarrhea____ Vomiting____ Allergies___

Frequent Fevers____ Sinus Trouble____ Nose Bleeding____ Bed Wetting____

Headaches____ Nightmares____ Nail Biting____ Heart Trouble____ Epilepsy____

Overtired or Lacking Pep____ Difficulty Hearing____ Difficulty Seeing____

COGNITIVE:

**Can your child count to ten? NO YES

**Can your child identify the 8 basic colors? NO YES
Red Blue Green Yellow Orange Purple Brown White

**Can your child name simple objects? NO YES

**Can your child accurately point to body parts when asked? NO YES

**Does your child state his own first and last name when asked? NO YES

**Does your child ask questions beginning with what, where, who, why and when? NO YE

VISION: **Has your child ever had a vision examination or treatment? NO YES

When:_____ Who:_____ Results:_____

Does your child:

1. Seem to have difficulty seeing small lines or pictures?	YES	NO
2. Seem to have a problem seeing things far away?	YES	NO
3. Squint?	YES	NO
4. Wear glasses?	YES	NO
5. Have eyes that turn in?	YES	NO
6. Have eyes that turn out?	YES	NO

HEARING:

**Have you had any worry about your child's hearing?_____

**Has your child had chronic ear infections?_____

Has your child ever been under medical doctor's care for ear problems?_____

Does your child have a cold now?_____

Is your child taking medicine for an ear infection now?_____

**Does your child have tubes in his/her ears?_____

Does your child:

**Sit too close and/or turn up the TV louder than other members of the family?_____

Seem to favor one ear over the other?_____

Jump or appear to be more startled than others if there is a sudden noise?_____

Seem to hear you if you talk in a whisper? _____

Make you talk loudly or repeat frequently?_____

_____

SPEECH/LANGUAGE:

At what age did your child say his/her first words?_____

At what age did your child begin using two and three word sentences?_____

Does your child talk frequently?_____Occasionally?_____Rarely?_____

To communicate, does your child use single words?_____
Two-Three word sentences?_____More than three word sentences?_____

**How understandable is your child's speech: (check one)

Easily understood?_____Understood if listener knows the topic?_____

Not understandable?_____Gestures understood?_____

Does your child understand what you say to him/her?_____

Can he/she follow simple commands?_____

**Do you have concerns about your child's ability to communicate? Explain:

_____

MOTOR: **Is your child's coordination up to normal expectations?
(walking running playing ball)

Can your child: (mark one) Place an X under the best answer

	Always	Sometime	Rarely	Don't Know
1. Walk up and down stairs one foot per tread, with no support?				
2. Turn knobs, push buttons, and hold a pencil or crayon in his/her fingers?				
3. Scribble or color on a piece of paper without going off the page?				

Your child began walking at what age (if guess, label as such)_____

SOCIAL/EMOTIONAL: **Is your child's behavior normal as per your expectations? YES NO
(Shy - Overly-Active - Quiet - Temper Tantrums

Does your child: (mark one)	Always	Sometimes	Rarely	Don't Know
1. Cry frequently or whine?				
2. Seem to be unusually quiet?				
3. Say "I can't" without trying?				
4. Have temper tantrums?				
5. Get upset easily?				
6. Sit still for up to 10 minutes to listen to a story or watch TV?				
7. Feed him/herself with spoon or fork?				
8. Have sleep disturbances?				
9. Eating disturbances?				

**Is your child toilet trained? No____ Yes____ At what age?_____

What does your child like to do at home?

Does your child do anything that bothers you? Explain:

_____

**Do you have any special concerns about your child?

Is there any other information that will help us to understand your child?

Do you have any specific questions of the screening team? Explain:

_____

**PLEASE CHECK (✓) IF YOU ARE CURRENTLY RECEIVING ANY OF THE FOLLOWING SERVICES:

EPSDT____
HEAD START_____
WIC_____
HOUSING ASSISTANCE_____
MEDICAL ASSISTANCE_____
FUEL ASSISTANCE_____
AFDC_____
FAMILY SUBSIDY_____
CRIPPLED CHILDREN'S_____
SOCIAL SERVICES_____
DEVELOPMENTAL DISABILITIES_____

PUBLIC HEALTH_____
EASTER SEALS RESPITE CARE_____
MEDICAL REHAB CENTER_____
HOME HEALTH CARE_____
CTL PRESCHOOOL PROGRAM_____
UND COMMUNICATION DISORDERS_____
DAY CARE OR PRESCHOOL:_____
SPECIAL THERAPY:_____
OTHERS: (list)_____
MEDICAL INSURANCE: (company)_____

Form completed by:_____ Date:_____

Relationship to child:_____

PUBLIC AWARENESS SHEET

Early Childhood Screening

(For 3 and 4 year old children)

The purpose of the screening is to identify children who are at risk for developmental delays and may be in need of early intervention services.

DATE: Thursday, April 26
TIME: 9:00 am - 2:00 pm
LOCATION: Wesley United Methodist Church

— Appointments are required —

*For more information or to pre-register call Head Start at **746-2433** prior to April 15, 1990.*

Screening takes approximately 1-1/2 hours in areas of:

HEARING	BASIC CONCEPTS	VISION
SPEECH/LANGUAGE	HEALTH	DENTAL/IMMUNIZATIONS

Sponsored by: Grand Forks Public Schools Special Services Dept.
Head Start — Early Childhood Tracking

MASTER SCREENING SCHEDULE

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM
SCREENING SCHEDULE

Screening Date: _____ *County or School District:* _____ *Screening Site:* _____

TIME	CHILD'S NAME	AGE	PARENT'S NAME	ADDRESS	TELEPHONE	COMMENTS

PARENT CONFIRMATION LETTER

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM

Project Coordinator, P.O. Box 5153, Grand Forks, ND 58206-5153 701-746-2200

April 25, 1990

Dear

The Grand Forks Public School District in conjunction with North Dakota Early Childhood Tracking will hold its next monthly developmental screening clinic on Thursday, May 3, 1990 between the hours of 9:00 a.m. and 2:00 p.m. at Wesley United Methodist Church, 1600 4th Avenue North.

This clinic will provide screening services in general development, speech and language, hearing and vision. In addition the Grand Forks Public Health Department will do dental checks, check your child's height and weight, review immunization records and offer free immunizations if desired.

This screening will take approximately one to one and a half hours. It will be done at no charge.

It has been recommended that your child would benefit from this screening.

Your scheduled time for _____

is on May 3 at _____

If you are unable to bring your child at the scheduled time of the screening or if you need a ride please call 746-2200. (Ask for either Linda Olson or Joan Norwood.)

Remember to bring along your child's updated immunization record and the enclosed developmental history form.

We look forward to seeing you and your child on, May 3, 1990.

Sincerely,

Linda Olson
Project Coordinator
North Dakota Early Childhood Tracking

NDECTS PRESCHOOL SCREENING

FOLDER COVER SHEET

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM
PRESCHOOL SCREENING FOLDER COVERSHEET

Screening Date: _____ School District: _____

CHILD'S NAME: _____ DOB: ____/____/____ AGE: ____ - ____
(month) (day) (year) (years) (months)

STATIONS

REGISTRATION:

Developmental History: Complete Incomplete Not Applicable (circle)

Income Verification: YES NO Not Applicable

HEALTH RESULTS:

Immunizations: Complete Incomplete Immunizations Needed Immunizations Given (circle)

Dental: Pass Refer Evaluate Comments:

Nutrition: Pass Refer Comments:

SCREENER(S): _____ _____

VISION RESULTS: Pass Refer Med-Refer Comments:
(circle)

SCREENER: _____

HEARING RESULTS: Pass Refer Med-Refer Comments:
(circle)

SCREENER: _____

COMMUNICATION RESULTS:

SPEECH: Pass Refer Evaluate Comments:
(circle)

LANGUAGE: Pass Refer Evaluate Comments:

SCREENER(S): _____ _____

GENERAL DEVELOPMENT RESULTS:

CONCEPTS: Pass Refer Evaluate Comments:
(circle)

FINE MOTOR: Pass Refer Evaluate Comments:

GROSS MOTOR: Pass Refer Evaluate Comments:

SCREENER(S): _____ _____

EXIT INTERVIEW

STAFF: _____ Comments:

Parent Information Requested: 108

SCREEN NUMBER: _____ TIME IN: _____ TIME OUT: _____

NDECTS HEALTH AND WELLNESS RECORD

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM

Health and Wellness Record

CHILD'S NAME: _____

Allergies: Yes No Comments:

Immunizations Current: Yes No

Immunizations Needed: _____ _____

_____ _____

SHOT RECORD: (record dates)

DPT: 1st Dose: ____/____/____ POLIO: 1st Dose: ____/____/____

2nd Dose: ____/____/____ 2nd Dose: ____/____/____

3rd Dose: ____/____/____ 3rd Dose: ____/____/____

4th Dose: ____/____/____ 4th Dose: ____/____/____

Booster: ____/____/____ Booster: ____/____/____

MMR: ____/____/____ HIB: ____/____/____

Screening Date	Height	Weight	BP	Hemoglobin	Urinalysis	Comments
1.						
2.						
3.						

NUTRITION: Pass Refer Comments:

DENTAL CHECK: Pass Rescreen Med-Referral

Comments:

OTHER:

NDECTS 3-5 SCREENING PROFILE

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM
3-5 Year Old Screening Profile

Child's Name: _____ **DOB:** ____ / ____ / ____ (month) (day) (yr.) **Age:** ____ - ____ (yrs.) (mo.) **Sex:** M F **School District:** _____

Parent(s): _____ **Phone:** _____ **Work Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Referral Date: ____/____/____ **Referral Source:** _____ **Referral Reason:** _____

Physician: _____ **Clinic:** _____ **Phone:** _____

Medical/Developmental History:

Parental Concerns:

SCREENING DATE	VISION	HEARING	HEALTH	DENTAL	SPEECH	LANG-UAGE	FINE MOTOR	GROSS MOTOR	CONCEPTS	TEAM DECISION	FOLLOW-UP RESPONSIBILITY
1. Age:											
2. Age:											
3. Age:											

SCORE CODE: P = Pass NP = No Pass I = Incomplete

DECISION CODE: 1 = Pass 2 = Pass/Refer 3 = Track/Refer 4 = Track/Rescreen 5 = Track/Evaluate

SCREEN APPOINTMENT SCHEDULED: DATE: _____ TIME: _____ CONFIRMED: _____

DATE: _____ TIME: _____ CONFIRMED: _____

DATE: _____ TIME: _____ CONFIRMED: _____

Comments:

DATE: ____/____/____ _____

_____

DATE: ____/____/____ _____

_____

DATE: ____/____/____ _____

_____

DATE: ____/____/____ _____

_____

INCOME INSPECTION FORM

SAMPLE

DIRECTIONS: Below is a list of INCOME GUIDELINES AND FAMILY SIZE. Please check the line which most nearly represents your TOTAL family income for 1990 and Circle your family size.

EXAMPLE: INCOME _____$12,100 FAMILY SIZE: 4

____	$ 5,980	1	_____$22,300	9
____	8,020	2	_____24,340	10
____	10,060	3	_____26,380	11
____	12,100	4	_____28,420	12
____	14,140	5	_____30,460	13
____	16,180	6	_____Over 30,460	
____	18,220	7	_____Welfare Recipients/AFDC/MA	
____	20,260	8	_____Other Financial Assistance Explain:	

Income is verified by parents pay statement, copy of income tax form, etc.

PARENT/CHILD INTERACTION

OBSERVATION FORM

CAREGIVER/CHILD INTERACTION OBSERVATIONS

CHILD'S NAME:_____ DATE:_____

Professional perception [with 1 indicating a "Low Level" and 5 indicating a "High Level", circle the appropriate number in each category]:

	No Problem				Severe Problem	NA/NK
Adjustment to temperament of child by caregiver	1	2	3	4	5	9
Difficult to soothe child	1	2	3	4	5	9
Diffuse cues child	1	2	3	4	5	9
Behavior problems	1	2	3	4	5	9
Nonresponsive child	1	2	3	4	5	9
Medical illness or acute medical problems	1	2	3	4	5	9
Physical appearance factors	1	2	3	4	5	9
Inappropriate or no response to needs of child	1	2	3	4	5	9
Inconsistent response to needs of child	1	2	3	4	5	9
Negative projection onto child	1	2	3	4	5	9
Lack of knowledge regarding child caregving	1	2	3	4	5	9
Inappropriate age expectation of child	1	2	3	4	5	9
Lack of provision of age appropriate experiences (specify:_____)	1	2	3	4	5	9
Ability to utilize resources to meet family's needs	1	2	3	4	5	9
Emotional investment in being a parent	1	2	3	4	5	9
Pleasure or enjoyment in child	1	2	3	4	5	9
Ability to balance needs of child, family and self	1	2	3	4	5	9
Level of stress	1	2	3	4	5	9
Adaquacy of support	1	2	3	4	5	9

SCORING DECISION GUIDE

SCORE CODE:

PASS = scores are within or above normal range.

NO PASS = scores clearly indicate a need for further evaluation.

INCOMPLETE = child's performance and/or screen results do not yield a clear decision, thus indicating the need for another screening.

DECISION CODE:

PASS = all areas of development are within or above normal range.

PASS/REFER = all areas of developmental skills are within or above normal range. Marginal concerns in one or more areas (ie, dental, social/emotional, health) thus indicating team recommendation of parental securement of other services (such as dental exam, preschool experience, parenting classes, etc.).

TRACK/REFER = child's scores are either NO PASS or INCOMPLETE accompanied with team opinion that provision of a temporary service will increase child's ability to pass another screening at a later date (ie, child receives speech or other specialized therapy, attends a group preschool experience, or receives medical attention).

TRACK/RESCREEN = child receives incomplete scores indicating a need for a re-screening at a later date.

TRACK/EVALUATE = child receives a NO Pass score indicating a direct referral for an evaluation to be completed by an agency (such as special education, Med Rehab, or other specialized services).

SCREENING RESULTS REPORT

MAY 3, 1990 SCREEN REPORT

NAME	AGE	STATUS	REFERRED TO	REASON	SERVICES RECEIVED	OTHER CONCERN
	4-6	TRACK/REFER	SUMMER CTL	GEN. DEVELOPMENT		RESCR.FALL IF NOT IN CTL
	3-4	PASS	HEAD START	WATCH VISION		SIB.NEEDS TO BE WATCHED
	5-4	PASS				
	3-5	PASS				
	4-1	PASS				
	3-10	PASS/REFER	PHYSICIAN	VISION/HEARING		
	4-3	NO SHOW	JUNE SCREEN			
	4-8	TRACK/RESCREEN	90/06/04SCREEN	VIS.20/40 20/30		RESCREEN DEVELOPMENT
	3-8	TRACK/RESCREEN	90/06/04SCREEN	COMPLETE SCREEN		UNCOOPERATIVE
	4-2	TRACK/RESCREEN	MAY 91 SCREEN	VISUAL MOTOR		
	3-10	TRACK/REFER	SUM.CTL/FALL HS	VISION/DEVELOP.	HEAD START 90-91	NEEDS EVAL. AT CTL
	4-3	TRACK	TRACKING	ACTIVITY LEVEL		VISION 20/30 20/30
	3-8	TRACK/REFER	90/06/04SCR/HS	VIS.20/70 20/40	HEAD START 90-91	
	4-6	TRACK/REFER	HEAD START	SP/LANG	HEAD START 90-91	RESCREEN IF NOT IN HS
	4-4	TRACK/EVAL.	PUBLIC SCHOOL	FULL EVALUATION		
	3-0	TRACK/RESCREEN	FALL SCREEN			
	3-8	TRACK/EVAL.	SUM.CTL/HS	SP.LAN./DEVELOP.	HEAD START 90-91	
	4-5	NO SHOW			HEAD START 90-91	
	3-6	PASS/REFER	EYE DR.	VIS.20/50 20/70		
	4-0	TRACK/REFER	90/06/04SCR/CTL	VISION		AGGRESSIVE BEHAVIOR
	4-2	TRACK/REFER	BASE DR./HS	MED.REF.HEARING		
	3-5	TRACK/RESCREEN	FALL SCREEN	SP/LANG/DEVELOP.		
	4-6	TRACK/REFER	HEAD START	SP/LANG.	HEAD START 90-91	
	4-5	TRACK/EVAL.	SUM.CTL	EVAL.		SP/LANG/DEVELOPMENT
	5-5	PASS	RECOM. CTL	LOW CONCEPTS		MOVING TO ENGL.ND
	2-9	TRACK/EVAL.	SUM.CTL/DENTIST	EVAL.		VIS./DEV./LANG./DENTAL
	4-3	TRACK/REFER	SUM.CTL/FALL HS	CONCEPTS LOW		
	4-8	PASS				
	4-4	PASS/REFER	DENTIST			
	3-9	TRACK/RESCREEN	FALL SCREEN	SP/LANG		VIS.20/40 20/40
	4-7	PASS/REFER	DENTIST/HS	BEHAVIOR		DENTAL
	3-9	TRACK/RESCREEN	DENT./SCREEN	FINE MOTOR		
	4-1	TRACK/REFER	HEAD START	SP/LANG/HEARING	HEAD START 90-91	MEDICAL REF. HEARING
	3-9	PASS				
	3-6	PASS/REFER	DENTIST			
	4-7	PASS/REFER	DENTIST	DENTAL		
	3-10	PASS				
	3-1	TRACK/EVAL.	SUM.CTL	EVALUATION		
	4-7	PASS/REFER	PHYSICIAN	VISION/HEARING		VIS.20/50 20/30
	3-7	TRACK/EVAL.	SUM.CTL	FULL EVALUATION		
	2-9	TRACK/EVAL.	SUM.CTL.	FULL EVALUATION		BROTHER SHOULD GO TO CTL
	3-9	TRACK/REFER	HEAD START	GEN. DEVELOPMENT	HEAD START 90-91	BEHAVIOR
	4-5	PASS/REFER	DENTIST	CAVITY		
	3-5	TRACK/EVAL.	SUM.CTL.	FULL EVALUATION		
	4-4	PASS/REFER	EYE DOCTOR	VISION		
	3-3	TRACK/EVAL.	SUM.CTL.	FULL EVALUATION		
	3-11	TRACK/EVAL.	SUM.CTL.	FULL EVALUATION		
	3-9	TRACK/EVAL.	SUMMER CTL	FULL EVAL.		
	3-2	TRACK/EVAL.	SUM.CTL.	FULL EVALUATION		
	4-7	PASS/REFER		DENTAL		
	3-6	TRACK/RESCREEN	90/06/04SCREEN	NO PARTICIPATION		MEDICAL HISTORY
	4-6	PASS		HEAD START REC.		
	3-10	PASS				
	3-8	TRACK/REFER	HEAD START	BEHAVIOR	HEAD START 90-91	SHY/NOT COOPERATIVE
	2-9	TRACK/REFER	CTL/TRACKING	SHY, EAR INFECT.		BEHAVIOR(DEFIANT)
	2-9	TRACK/REFER	CTL/TRACKING	HEARING		SPEECH/HEARING
	2-10	TRACK/EVAL.	PUBLIC SCHOOL	FULL EVAL.		

MAY 3, 1990 SCREEN REPORT

NAME	AGE	STATUS	REFERRED TO	REASON	SERVICES RECEIVED	OTHER CONCERN
	3-6	NO SHOW	JUNE SCREEN			
	3-5	TRACK/RESCREEN		VISION/HEARING		VISION/HEARING/DENTAL
	4-4	PASS				
	4-10	PASS				
	4-1	PASS				
	3-4	TRACK/RESCREEN	FALL SCREEN	DEVELOPMENT		VISION 20/40 20/40
	3-4	TRACK/RESCREEN	SCREEN	EXPRESSIVE LANG.		
	3-11	TRACK/REFER	SUM.CTL/FALL HS	DEVELOPMENT	HEAD START 90-91	VISION 20/40 20/40
	3-8	TRACK/REFER	SUM.CTL	DEVELOPMENT	HEAD START 90-91	RECHECK HEARING
	4-3	TRACK/REFER	SUM.CTL/FALL HS	SP/LANG./DEVEL.	HEAD START 90-91	VIS.20/30 20/30
	4-3	TRACK/EVAL.	SUM.CTL	FULL EVALUATION		

PASS	13
PASS/REFER	10
TRACK/REFER	16
TRACK/RESCREEN	11
TRACK/EVAL	14
NO SHOW	3

SAMPLE LETTERS TO PARENTS

June 7, 1990

Parent's Name
address
city, state zip
Home Phone:
Work Phone:

Re:

Dear

On June your child was screened by professionals from the North Dakota Early Childhood Tracking Project. Your child received screening in the following areas:

(X)Vision (X)Hearing (X)Health (X)Dental
(X)Speech/Language (X)Motor (X)General Concepts

The team reviewed your child's scores and reported the following results:

Vision-Pass Hearing-Pass Health-Pass
Speech/Language-Pass
Dental-Pass Motor-Pass Concepts-Pass

As follow-up of these results and for continued monitoring of your child's development, these are the recommendations of the team:

All areas of development appear normal. No further services needed.

I hope that you have found our services to be of help to you and your child. If you have any further questions, please contact me at 746-2200.

Sincerely,

Linda Olson
Project Coordinator

BEST COPY AVAILABLE

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM

Project Coordinator, P.O. Box 5153, Grand Forks, ND 58206-5153 701-746-2200

COPY

May 14, 1990

Re:

Dear

On May 3 your child was screened by professionals from the North Dakota Early Childhood Tracking Project. Your child received screening in the following areas:

()Vision ()Hearing ()Health ()Dental
(X)Speech/Language (X)Motor (X)General Concepts

The team reviewed your child's scores and reported the following results:

Vision- Hearing- Health-
Dental- Speech/Language-Pass Motor-Pass
Concepts-Pass

As follow-up of these results and for continued monitoring of your child's development, these are the recommendations of the team:

Passed speech/language and general development rescreen. No further services needed.

I hope that you have found our services to be of help to you and your child. If you have any further questions, please contact me at 746-2200.

Sincerely,

Linda Olson
Project Coordinator

June 7, 1990

Parent's Name
address
city, state zip
Home Phone:
Work Phone:

Re:

Dear

On June your child was screened by professionals from the North Dakota Early Childhood Tracking Project. Your child received screening in the following areas:

(X)Vision (X)Hearing (X)Health (X)Dental
(X)Speech/Language (X)Motor (X)General Concepts

The team reviewed your child's scores and reported the following results:

Vision-Pass Hearing-Pass Health-Pass
Speech/Language-Pass
Dental-Refer Motor-Pass Concepts-Pass

As follow-up of these results and for continued monitoring of your child's development, these are the recommendations of the team:

Passed all developmental and health areas. Recommend dental examination as soon as possible.

I hope that you have found our services to be of help to you and your child. If you have any further questions, please contact me at 746-2200.

Sincerely,

Linda Olson
Project Coordinator

June 7, 1990

COPY

Re:

Dear

On June your child was screened by professionals from the North Dakota Early Childhood Tracking Project. Your child received screening in the following areas:

(X)Vision (X)Hearing ()Health ()Dental
(X)Speech/Language (X)Motor (X)General Concepts

The team reviewed your child's scores and reported the following results:

Vision-Pass Hearing-Pass
Speech/Language-Evaluate
Motor-Pass Concepts-Pass

As follow-up of these results and for continued monitoring of your child's development, these are the recommendations of th team:

Track and refer to UND Communication Disorders Clinic for a speech/language evaluation. Parents should call 777-3232 for more information. Please sign and take the encolsed referral form with you to the evaluation.

I hope that you have found our services to be of help to you and your child. If you have any further questions, please contact me at 746-2200.

Sincerely,

Linda Olson
Project Coordinator

cc: Audrey Glick

June 7, 1990

COPY

Re:

Dear

On June your child was screened by professionals from the North Dakota Early Childhood Tracking Project. Your child received screening in the following areas:

(X)Vision (X)Hearing ()Health ()Dental
(X)Speech/Language (X)Motor (X)General Concepts

The team reviewed your child's scores and reported the following results:

Vision-Pass Hearing-Refer
Speech/Language-Refer
Motor-Pass Concepts-Pass

As follow-up of these results and for continued monitoring of your child's development, these are the recommendations of the team:

Track and refer to summer CTL Preschool Program for preschool experience. During child's attendance at CTL a speech/language eval will be conducted through UND Speech Language Communications Disorders. The speech/language evaluation will be paid for by the Grand Forks Public Schools. Parents should call Lynne Locklage at 777-3661 for more information on summer CTL Program. Please sign and take the enclosed referral form with you to the evaluation. Head Start application on file.

I hope that you have found our services to be of help to you and your child. If you have any further questions, please contact me at 746-2200.

Sincerely,

Linda Olson
Project Coordinator

cc: Lynne Rocklage
Cookie Mitchell
Penny Ackerland

COPY

May 24, 1990

Re:

Dear Lana,

On May 3 your child was screened by professionals from the North Dakota Early Childhood Tracking Project. Your child received screening in the following areas:

(X)Vision (X)Hearing (X)Health (X)Dental
(X)Speech/Language (X)Motor (X)General Concepts

The team reviewed your child's scores and reported the following results:

Vision-Pass Hearing-Pass Health-Pass
Dental-Pass Speech/Language-Rescreen
Motor-Rescreen Concepts-Rescreen

As follow-up of these results and for continued monitoring of your child's development, these are the recommendations of th team:

Track and rescreen development in the fall.
Parents will be contacted regarding fall screening.

I hope that you have found our services to be of help to you and your child. If you have any further questions, please contact me at 746-2200.

Sincerely,

Linda Olson
Project Coordinator

PARENT INSTRUCTIONS: Please take or send this form to your child's appointment.

NORTH DAKOTA EARLY CHILDHOOD TRACKING SYSTEM
REFERRAL AND REQUEST FOR INFORMATION

Date: _____ RE: _____
(Child's Name)

To:

_____
(Service Provider)

_____
(Address)

_____
(Phone)

THIS CHILD WAS SCREENED BY A NDECTS TEAM MEMBER AND IS REFERRED TO YOU FOR THE FOLLOWING REASON(S):

APPOINTMENT RESULTS:

PROVIDER INSTRUCTIONS: So that we may assist this child in the completion of all necessary treatment, please complete the following and return to:

_____

_____

Appointment Date: _____ _____

Method of Examination:

Findings:

Treatment/Recommendations:

Prescriptions: YES NO # Of Additional Visits Needed: _____

Appointment(s) Made: _____
(Date)

* I approve of this request for services and I agree to have the resulting information shared with the North Dakota Early Childhood Tracking System and its cooperating agencies.

* _____ Date: _____
(Parent Signature)

_____
(Provider Signature)

Distribution:
Original: NDECTS Team Member
Second: Parent
Third: Provider File
Fourth: Referral Source
Fifth: Child File Copy

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